

**EVALUATION OF THE  
PRIMARY PROVIDERS' TRAINING  
AND EDUCATION IN  
REPRODUCTIVE HEALTH  
(PRIME) PROJECT**

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, or the staffs of these organizations.

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## ACRONYMS

ACNM	American College of Nurse Midwives
AMZCO	AMZCO Surgical Devices, USA
ANM	Auxiliary Nurse Midwives
APHA	American Public Health Association
AVSC	AVSC International
CA	Cooperating Agency/Cooperative Agreement
CBD	Community Based Distribution (Distributors)
CMT	Communication, Management, and Training Division (USAID)
CPI	Client-Provider Interaction
CPSM	Community Partnership for Safe Motherhood
CTO	Cognizant Technical Officer
DAPP	Diagnostic Assessment of Performance Potential
DISH	Delivery of Improved Services for Health (Uganda)
EC	Emergency Contraception
EDD	Evaluation, Documentation, and Dissemination Initiative
FGC	Female Genital Cutting
FHI	Family Health International
FOCUS	FOCUS on Young Adults Project
FP	Family Planning
G/PHN/POP	Bureau for Global Programs, Field Support and Research, Center for Population, Health and Nutrition, Office of Population
GRMA	Ghana Registered Midwives Association
HIV	Human Immuno-Deficiency Virus
HPT	Human Performance Technology
IEC	Information, Education and Communication
ILA	Innovative Learning Approaches
IMSS	Instituto Mexicano del Seguro Social
INTRAH	Program for International Training in Health, University of North Carolina
IR	Intermediate Result
IRH	Integrated Reproductive Health
ISM	Indigenous Systems of Medicine
ISMP	Indigenous Systems of Medicine Provider
ISPI	International Society of Performance Improvement
IUD	Intrauterine Device
JHPIEGO	The Johns Hopkins Program for International Education in Reproductive Health
JSI	John Snow, Inc.
LAC	Latin America and the Caribbean (Region)
LOE	Level of Effort
LSS	Life Saving Skills
MDG	Management Development Group
MH	Maternal Health
MOH	Ministry of Health
OJT	On-the-Job Training

OH	Office of Health
OP	Office of Population
OR	Operations Research
PAC	Postabortion Care
PATH	Program for Appropriate Technology in Health
PI	Performance Improvement
PIA	Performance Improvement Approach
PPAG	Planned Parenthood Association of Ghana
PRIME	Primary Providers' Training and Education in Reproductive Health Project
RH	Reproductive Health
ROANE	Regional Office for Asia and the Near East
SIFPSA	State Innovations in Family Planning Services Agency
SFPS	Family Health and AIDS Prevention Project
SM	Safe Motherhood
STI	Sexually Transmitted Infection
SO	Strategic Objective
TA	Technical Assistance
TG/CWG	Technical Guidance/Competence Working Group
TNA	Training Needs Assessment
TRG	Training Resources Group
TBA	Traditional Birth Attendants
UNC	University of North Carolina
USAID	United States Agency for International Development
USAID/W	United States Agency for International Development/Washington

## PROJECT IDENTIFICATION DATA

**Project Title:** The Primary Providers' Training and Education in Reproductive Health Project (PRIME)

**Country:** Global

**Contract:** CCP-3072-C-00-5005-00

**Contract Dates:**

Start Date: January 1995  
End Date: December 1999

**Contract Funding**

Obligations to Date: \$45,111,800

Core (C): \$45,111,800

**Mode of Implementation:** Contract between the Office of Population, the Global Bureau, and the University of North Carolina School of Medicine

**Contractor:** INTRAH, University of North Carolina  
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## EXECUTIVE SUMMARY

This report documents the final evaluation of the Primary Providers' Training and Education in Reproductive Health Project (PRIME). The objectives of the evaluation are:

1. to identify the major technical and programmatic strengths and weaknesses of the project;
2. to assess the effectiveness of PRIME's approach to building national capacity for training and to foster sustainable development;
3. to provide recommendations for the design and implementation of a follow-on project.

### Major Results

The project successfully completed, or is on track to complete, deliverables specified in its contract. It has also made significant strides to emphasize the key results areas negotiated with USAID during 1997 and 1998, as the project underwent a major management restructuring. Primary accomplishments include:

- reaching new cadres of reproductive health (RH) primary providers;
- expanding RH services and the mix of services;
- decentralizing training;
- focusing on quality through guidelines, training, materials, monitoring and supervision, counseling, and Client-Provider Interaction (CPI);
- experimenting with innovative learning approaches;
- building training and resource planning capacity;
- initiating a systems approach to training.

The project has demonstrated technical leadership and pioneered new initiatives:

- **Postabortion Care (PAC):** The PRIME Project has played a major role in decentralizing postabortion care services and increasing access to services closer to where women live
- **Policy, Guidelines and Standards:** The project has made an important contribution in linking policies, guidelines and standards with training and the follow-up of provider performance
- **Performance Improvement Approach (PIA):** It appears that PIA is a valuable tool linking training and non-training interventions to improve provider performance

While important strides have been made in the training of primary providers, additional progress has been hampered by several factors:

- Lack of comprehensive strategic planning for training that includes analysis of alternative training strategies, analysis of cost, identification of appropriate exit strategies, trainee selection criteria, and pre-training service performance
- Insufficient development and testing of alternative learning approaches
- Lack of focus on pre-service institutions
- Insufficient attention paid to men and adolescents as populations with special needs

- Limited integration of emergency contraception (EC), female genital cutting (FGC), or sexually transmitted infection (STI) prevention in training curricula

## **Building Capacity for Training and Performance Improvement**

Training conducted by PRIME is state-of-the-art performance-based training, including participation and use of anatomical models for practicing clinical skills, based upon approved protocols and guidelines for service providers. PRIME has exceeded its targets for number of trainers and service providers trained and curriculum packages developed.

A major accomplishment of PRIME has been to decentralize training and to extend high-quality performance-based training into new areas of reproductive health and new levels of service providers. PRIME has prepared curricula and training manuals and trained trainers for Auxiliary Nurse Midwives (ANMs), Indigenous Systems of Medicine Providers (ISMPs), and Traditional Birth Attendants (TBAs). A second major accomplishment is the development of capacity for systematic follow-up and monitoring of training. However, it appears that follow-up visits often focus on data collection and do not provide opportunities to motivate providers or help them identify and remove barriers to performance. The major problem with PRIME's training programs is that, in reaching out to new cadres and new RH areas, training and follow-up is staff-intensive, expensive, and difficult to sustain.

PRIME has introduced Innovative Learning Approaches (ILA) in selected projects to test more cost-effective training approaches, with emphasis on low-tech, sustainable training systems. PRIME identifies three areas in which it is testing new learning models:

- Integrated, multiple delivery systems such as distance learning and on-the-job training
- New technologies such as low-cost solar-powered tape recorders, self-directed learning modules, and radio-based instruction
- Traditional methods used in new ways or with new groups

While these ILAs have great potential for decreasing time away from the job for training, increasing learning achievement, and lowering cost per trainee, benefits have not yet been fully demonstrated, although promising studies are under way in several countries.

The Performance Improvement Approach (PIA) is a systematic methodology for performance analysis and change. It is based upon careful analysis of performance gaps in a particular cadre of service providers, identification of the causes of those gaps, and design and implementation of interventions to remedy the gaps. In 1997 PRIME identified PIA as a promising approach and pioneered adaptations of the methodology for use in international FP/RH settings. Although many aspects of the approach have been incorporated into previous FP/RH performance-based training approaches, PRIME pioneered the full application of performance improvement (PI) in this setting.

Based upon the work done in three pilot PIA projects, some valuable lessons have been learned about the application of PIA in PRIME:

- PI is a potentially powerful tool for linking system interventions to service results
- Pilot projects have been expensive due to heavy reliance on external expertise
- PIA tools need to be made more practical and accessible for field use
- Materials are needed to train PIA leaders and facilitators at the local level
- Existing training capacity (trainers, facilitation skills, training curricula, and materials) can be utilized effectively in PI projects
- Natural linkages exist between Maximizing Access and Quality (MAQ) and PI as both deal with identifying the conditions necessary for increased access and quality
- Research is needed to determine the least costly combinations of interventions needed to achieve improved performance

### **Maximizing Access and Quality/Global Technical Leadership**

The evaluation team found consistent evidence of PRIME’s commitment to the MAQ goals and strategy. Features of PRIME’s MAQ strategy include:

- focus on essential primary personnel;
- integration of selected RH interventions;
- addressing provider needs and performance beyond training;
- policy activities;
- attention in training to counseling and other CPI skills;
- replicable and sustainable systems, approaches, and materials;
- culturally appropriate strategies.

PRIME’s technical, clinical, and programmatic contributions to improvement of family planning, postabortion care (PAC), STI prevention, and maternal health have been significant. In particular, the expansion of PAC and life saving skills (LSS) capabilities to the community level will allow women who previously were unable to obtain life saving services due to limitations of transport or resources to receive timely treatment.

PRIME’s limited definition of its technical advisory role may foster a “disconnection” between PRIME’s goals and the reality of PRIME’s effectiveness in the field. That is, once PRIME has provided technical assistance (TA) in curriculum development, training, or supervisory systems, it often takes a “hands off” approach, encouraging partners to take a major role in implementation. While fostering local capacity building, this strategy sometimes leads to inadequate or inappropriate monitoring of the progress of initiatives in the field. More time and attention is needed in overseeing program implementation to detect and remedy problems early.

PRIME needs to shift its focus from the development of complex theoretical models to finding what works in the field. PRIME’s PIA has the potential for achieving this goal. The challenge will be to present this tool as a simple, user-friendly model.

### **Capacity Building, Institutionalization, and Sustainability**

PRIME attempts to strengthen capacity at all stages of project development, from initial negotiations to evaluation. In programs in which PRIME has a substantial role, staff work with

counterparts to develop long-range strategic plans with objectives and benchmarks, ensuring local commitment and resource allocation. Efforts are made to develop monitoring materials to self-evaluate the planning and implementation process. Wherever feasible, the training focus is shifted from improving knowledge and skills to improve provider performance.

While many elements of the training system (materials, curricula, and trainers) are well developed to contribute to capacity building, and the process of project design and implementation may contribute to institutionalization, sustainability of many training systems remains vulnerable. In particular, emphasis on systems approaches and performance improvement demands that greater attention be paid to the development of planning and data-based decision-making skills.

## **Monitoring and Evaluation**

Monitoring and evaluation activities are carried out in virtually every PRIME sub-project. However, evaluation indicators and monitoring instruments designed by PRIME staff are not always used effectively. When monitoring and evaluation data are collected the data are frequently not fully analyzed nor utilized for program planning, decision-making, and performance improvement. PRIME's system for tracking and measuring progress and achievements of results can be strengthened by:

- allocating more resources in staff time and money for monitoring, evaluation, and research activities to better document results;
- simplifying and reducing the number of indicators and checklists used in monitoring and evaluation activities;
- avoiding development of too many different kinds of models and indexes, especially those that have unduly heavy data collection requirements.

## **Documents and Publications**

PRIME publications fill an important niche by providing baseline materials for the development of more specifically targeted publications, thereby eliminating duplication of effort and improving quality of locally produced materials. While all of the materials reviewed were of good quality, they seemed to be written for a very sophisticated user. The number and complexity of the instruments and checklists overwhelm many of the end users of these tools. Also, the language level of many of the manuals and instruments makes them difficult to use.

PRIME has not adequately told the story of its accomplishments, successful innovations, and lessons learned. USAID Missions, international agencies, other contractors, and the larger community of health care professionals need information presented in a usable and attractive format.

## **Management**

PRIME and USAID staff agree that the new organizational and management structure, coupled with additional technical staff, has enhanced the ability of the project to respond effectively to

the diverse needs of a global project. Headquarters, regional and partner staff, and USAID collaborated to develop an integrated structure with nearly seamless participation among five partner organizations. This has increased and facilitated access to the technical strengths of each partner by USAID field missions and host country counterparts. Partners are fully engaged in strategic planning and reviewing results, and there is transparency regarding project resources, fostering group equilibrium.

Field visits, mission e-mail replies, and discussions with local counterparts confirm that field offices are advantageous in relating to customers. Nevertheless, administrative and contracting procedures frequently slow responsiveness, and reduce local decision-making authority. Streamlining review procedures and developing more budgetary autonomy would contribute to enhanced flexibility and responsiveness to local requests.

### **Follow-on Project**

PRIME's programmatic and technical approaches are appropriate, and should be continued in a follow-on project targeting primary providers. These include:

- decentralization of PAC and its links to postabortion FP service delivery;
- LSS and Community Partnerships for Safe Motherhood show potential for increasing awareness and responsiveness to women's reproductive health needs, improving women's value in the community, and generating community demand for quality RH/FP services;
- increasing male involvement including couple communication, recognizing the male role in FP/RH decision-making as well as his own needs for FP services;
- increasing focus on emergency contraception;
- increasing focus on adolescent services including removing cultural barriers and finding innovative ways to offer information and services;
- increased focus on STI/HIV prevention.

The systems approach to improving performance is rapidly replacing training in international business and industry and, increasingly, in health care organizations. This technology is often called Human Performance Technology (HPT).

PRIME, having recognized that "training is not enough," is adapting the HPT strategy to improve provider performance in FP/RH projects. Early results of evaluation studies of these PIA projects are very promising. They demonstrate that the PIA:

- produces positive results in the improved performance of service providers;
- involves a variety of stakeholders in the identification of problems and implementation of solutions;
- can effectively utilize existing training capacity (trainers, curricula, materials);
- can identify cost-effective interventions.

If the follow-on project is oriented toward the HPT paradigm, the following capabilities will be required:

- Improve strategic planning for performance improvement
- Test PIA in a wider variety of projects and countries, and evaluate the costs and effectiveness of the methodology for improving performance of providers
- Develop PIA tools and training materials that can be used by project personnel with minimal outside technical expertise
- Develop more cost-effective training and non-training interventions for improving performance
- Increase capability to evaluate cost-effectiveness of alternative learning approaches and performance improvement interventions
- Develop capability of training organizations to market and obtain revenues for designing and conducting training for private sector providers and other health and non-health organizations
- Conduct more effective needs assessments to determine who truly needs training, how much, and when they have reached a determined level of competence
- Change the concept of training to a truly performance-based approach; that is, provide only those skills and knowledge needed to become a competent service provider
- Make better and more efficient use of the performance-based training approach by increasing the student-instructor ratio, standardizing materials and training curricula, and utilizing slides, video, and other technologies
- Conduct studies to determine the minimum amount of skill practice on models and clients required to attain competency

## RECOMMENDATIONS

1. PRIME should establish better linkages between training interventions and performance results by improving strategic planning for skills and strengthening the follow-up monitoring of service performance.
2. PRIME should increase the sustainability of its training approaches by finding the least costly, most effective approaches to training and performance improvement. Cost-effectiveness studies should be conducted.
3. To make the Performance Improvement Approach a more useful tool for the project personnel, PRIME should simplify PIA tools and materials and develop training curricula for PIA leaders. To the extent possible in the remaining project period, an effort should be made to test PIA in larger projects and in a greater variety of situations, perhaps by partnering with other agencies doing PIA-related work.
4. PRIME should intensify efforts to move from training intervention to results orientation and strengthen linkages between training and measures of performance at service levels.
5. Greater emphasis is needed on follow-up and supervision at the field level to change old patterns of dogmatic service delivery and authoritative supervision.
6. PRIME should develop leadership capabilities among primary providers. Efforts should be made to identify and recruit those individuals who show promise and provide them with training and support in leadership and management skills.
7. PRIME should increase emphasis on developing training program management skills, including program planning, financial resource allocation, human resource recruitment and deployment, and timeline preparations. PRIME should utilize commercially available software with the potential for spin-off applications in other RH domains.
8. PRIME should test the applicability of the Index of Capacity Building Indicators in Training in three sites and assess the utility and comparability of the results to determine whether the Index is a useful tool. If yes, complete final adaptations and prepare a technical report for circulation. If no, suspend further work on the Index.
9. PRIME should convene a working group among CAs, or draft a document for circulation among CAs, detailing feasible strategies and incentives for collaboration. This document should be submitted for discussion with the USAID PHN Center.
10. Study results and technical reports that detail project accomplishments and lessons learned should be more widely disseminated to CAs, and to USAID Missions, regional offices, and training organizations.
11. Research and evaluation dissemination topics should be included in planned end-of-

project regional workshops. The most significant results presented at the workshops should be presented at the final project dissemination seminar.

12. PRIME should continue to focus its efforts on publications that can serve as a template for materials development particularly at the primary provider level. As part of this process, instruments and checklists should be simplified and those that are not useful to field personnel eliminated.
13. Review procedures should be streamlined and greater budgetary autonomy allocated to the regional offices in order to enhance flexibility and responsiveness to local requests.



# **1. OVERVIEW: EVALUATION METHODOLOGY AND SUMMARY OF PROJECT PERFORMANCE**

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## **1.1 Introduction**

This report documents the final evaluation of the Primary Providers' Training and Education in Reproductive Health Project (PRIME). The five-year, US \$50.5 million project contract was signed in January 1995, and will be completed December 22, 1999. PRIME is implemented by INTRAH (Program for International Training in Health, University of North Carolina at Chapel Hill, and its partner organizations: American College of Nurse Midwives (ACNM); Ipas; Program for Appropriate Technology in Health (PATH); Training Resources Group (TRG); AMZCO, Inc.; and Overseas Marketing Group Booksource, Inc.

The second purpose of the evaluation is to provide information for the redesign for the follow-on project. Fifty percent of the evaluation team effort was devoted to assessing the accomplishments and impact of the current project, and fifty percent focused on the future needs of USAID/ Washington, USAID Missions, and host country counterparts, taking into account new and emerging issues relevant to training and improved job performance.

The objectives of the evaluation are:

- to identify the major technical and programmatic strengths and weaknesses of the project;
- to assess the effectiveness of PRIME's approach to building national capacity for training and to foster sustainable development;
- to provide recommendations for the design and implementation of a follow-on project.

The scope of work for the evaluation is attached as Appendix A.

## **1.2 Purpose of PRIME**

The purpose of the PRIME contract is to provide the Bureau for Global Programs, Field Support and Research, Center for Population, Health and Nutrition, Office of Population (G/PHN/POP) with technical assistance to develop the capacity of host country institutions to train their own primary FP/RH service providers. The PRIME project is a follow-on to the Paramedical, Auxiliary and Community Personnel (PAC I and PAC II) Projects which USAID has supported since 1979. PRIME is the leading Office of Population project providing training to primary health personnel reaching clients at the most basic level of service delivery.

The goal of the project is to improve the reproductive health of women and men in developing countries by increasing access to and the quality of family planning (FP) and other reproductive health (RH) services. The focus of the project is to provide technical assistance to institutionalize training and to ultimately move countries to achieve a sustainable training system. In response to changing USAID priorities, the PRIME project was designed as an integrated reproductive health (IRH) project, expanding on the work of PAC I and II by including other selected RH care interventions into family planning training programs to better respond to client needs. As warranted by field requests, the PRIME project was expected to incorporate sexually transmitted

infection (STI) prevention and control, safe motherhood, breastfeeding, and prevention of female genital cutting (FGC) into family planning training to enable providers to reach new client groups and increase the quality and utilization of family planning services.

An emphasis of the project is to develop the capacity of host countries to train their own personnel and strengthen national training systems, including both pre-service and in-service training. The project mandate was also broadened from training to human resources development, focusing on the management and deployment of trained personnel, as well as provider training. Prior projects emphasized training in isolation, neglecting to account for the effects of the enabling environment. The PRIME project was positioned to examine and develop interventions to create a supportive environment for service providers to maximize training inputs. Interventions identified in the contract include: strategic planning, management, and supervision; deployment of personnel; policy and quality issues; gender barriers, etc.

Other areas of emphasis in the project design are the collection of impact data and the linkage between training and improved quality of service delivery. The project was expected to measure the impact of training on service delivery and to develop indicators to measure the sustainability of training activities.

### **1.3 Evaluation Methodology**

The evaluation team included four professionals:

Susan Adamchak, Ph.D., Policy and Management Specialist (Team Leader)  
Gary Bergthold, Ph.D., Training and Performance Specialist  
A. August Burns, C.M., P.A., MPH, Clinical Specialist  
Thomas T. Kane, Ph.D., Evaluation and Research Specialist

Fieldwork was carried out from January 20 to February 17, 1999. The team used a variety of qualitative rapid appraisal methods, including interviews with key informants, direct observation, document review, and role playing (see Appendix A for the scope of work, Appendix B for a bibliography, and Appendix C for a list of contacts). The team conducted several interviews with Cooperating Agency (CA) and USAID/Washington staff in the United States, and participated in a detailed briefing with PRIME staff at project headquarters in Chapel Hill, North Carolina. Site visits took place in the state of Uttar Pradesh, India (Varanasi, Agra, Kanpur, and Lucknow), and in Ghana (Accra, Koforidua, and Awufu). Debriefings were held with PRIME staff on February 16, and with USAID/Washington on February 17, 1999.

The remainder of this chapter summarizes overall project performance. Chapters 2 through 7 of this report present the findings, conclusions, and recommendations of the evaluation for the current PRIME project. Chapter 8 contains suggestions for the follow-on project.

### **1.4 Major Results and Accomplishments of PRIME Project**

### 1.4.1 Major Results

The project successfully completed, or is on track to complete, deliverables specified in its contract (see Appendix D). In addition, it has made significant strides to emphasize the key results areas negotiated with USAID during 1997 and 1998, as the project underwent a major management restructuring. The PRIME project has effectively:

- reached new cadres of RH primary providers (Auxiliary Nurse Midwives (ANM), Traditional Birth Attendants (TBA), Midwife assistants, Community Based Distributors (CBD), and Indigenous System of Medicine Providers (ISMP));
- expanded RH services and mix of services;
- decentralized training;
- focused on quality through guidelines, training, materials, monitoring and supervision, counseling, and Client-Provider Interaction (CPI);
- experimented with innovative learning approaches;
- built training and resource planning capacity;
- initiated systems approach to training.

### 1.4.2 Technical Leadership and New Initiatives

- **Postabortion Care (PAC):** The PRIME project has had a major role in the decentralization of PAC providers leading to expanded availability of care within communities where women live. Integration of PAC in RH service packages by a broader array of service cadres has resulted in a growing desensitization of PAC issues.
- **Policy, Guidelines, and Standards:** The project has made an important contribution in linking policies, guidelines, and standards with training and the follow-up of provider performance. Adoption of policies, guidelines, and standards facilitate the removal of medical barriers. They expand the opportunities and abilities of primary providers to offer services not previously permitted. They also serve as essential tools in advocacy efforts to expand the nature and scope of RH services.
- **Performance Improvement Approach (PIA):** While it is too early to assess the impact of PIA, it appears to be a valuable tool linking training and non-training interventions to improve provider performance. PIA provides guidance for developing sustainable systems by identifying cost-effective interventions to improve provider performance. It can provide a framework to engage multiple stakeholders in addressing program needs beyond training. A shortcoming is that it is too dependent on external expertise, with local capacity not yet developed to use the approach. Also, the engagement of key stakeholders may not be foreseen at the outset of the process, and subsequent results may require intense lobbying among CAs and/or donor organizations to enlist needed support for non-training interventions.

### 1.4.3 Areas of Limited Results or Technical Weakness

The evaluation notes that PRIME performance has been hampered by several limitations:

- There is a lack of comprehensive strategic planning for training that includes analysis of alternative training strategies, analysis of cost, identification of appropriate exit strategies, trainee selection criteria, and pre-training service performance
- There has been insufficient development and testing of alternative learning approaches
- There has been a lack of focus on pre-service institutions (attributable in part to the low priority given pre-service training by USAID Missions)
- Superficial attention has been paid to men and adolescents as populations with special needs
- There has been limited integration of emergency contraception (EC), FGC, or STI prevention in training curricula

#### **1.4.4 Reasons for Limited Results**

- Insufficient time in the project due to changes in the initial management structure and staff allocation.
- The lack of a training specialist or instructional technologist on staff with expertise in innovative learning approaches (ILA) compromised development and testing of these approaches.
- Lack of USAID Mission support for ILA (and for programmatic emphasis on EC, FGC, STI treatment), coupled with inadequate promotion of innovative technical and programmatic approaches in the field resulted in few opportunities to apply new training methods.
- The project shows inadequate follow-through from theory into practice, and is suffering internally from lack of documentation of project successes.
- Changing international treatment protocols, particularly those reconsidering cost and effectiveness of syndromic management of STIs, have inhibited their introduction in training curricula.

<b>Box 1: PRIME Project Strengths and Limitations</b>	
<i>Strengths</i>	<i>Limitations</i>
<b>Maximizing Access and Quality</b>	
Commitment to increased access to and quality of primary care providers.	Limited on-site supervision to ensure quality that may be diluted through cascade training.
Introduction of valuable RH and maternal mortality interventions in training (PAC, Life Saving Skills (LSS)).	
Consistent emphasis on counseling and client-provider interaction as measures to improve quality.	Counseling and CPI models may be strengthened with integration or adaptation of more culturally appropriate techniques.
Decentralized project structure with strong regional staffs.	Partnership is considered expensive, but provides administrative and management relief for USAID.
Input of project partners results in an appropriate integrated RH package.	There are constraints in coordinating partner inputs with field needs (conflicts in timing, work plans, language capability).
<b>Training</b>	
Sustained emphasis on performance-based training.	Continued reliance on traditional instructional methods, i.e., costly residential training courses of long duration, rather than strengthening supervisors, training at local sites, on the job training (OJT), etc.
Application of training needs assessments (TNA).	TNAs measure knowledge and skills, not performance; are prone to overstate need for training; are not always used well to allocate training. Approach needs to be more strategic, including alternative training models and cost calculations.
Follow-up to training.	Follow-up focuses on performance, but supervisors may emphasize skills and knowledge. Often is conducted as monitoring, rather than stressing problem solving, motivational aspects, or on-the-job training. Can be costly.
Experiments with distance learning approaches show positive results; provide foundation for more efficient and cost-effective training.	Insufficient attention paid to implementing alternate instructional models on a large scale.

<b>Sustainability</b>	
Recognition that policies, guidelines, standards, and protocols are essential to strong RH programs. Where developed and disseminated, have been extremely valuable in creating a unified vision among stakeholders.	Few protocols developed for community level application; need simple, visually-oriented tools for low literacy audiences.
Identified and labeled planning processes: PIA, Index of Capacity Building Indicators.	Models describing processes are complex and described in jargon-laden and incomprehensible materials. Simple ideas are made too complicated to be useful.
Strengthening long-range planning skills within counterpart institutions.	Continued efforts needed to foster data-based decision-making.
Promising results achieved in new learning approaches and addition of RH content.	Project had no communications unit for first 4 years, hindering production and dissemination of useful findings and tools. Important results achieved are neither effectively communicated nor attractively packaged for multiple project audiences.
<b>Monitoring and Evaluation</b>	
Recently strengthened Monitoring and Evaluation Unit at headquarters.	<p>Monitoring tools and manuals are not user-friendly (e.g., supervisor checklists).</p> <p>Few evaluations of provider performance and impact of training on service utilization conducted.</p> <p>Focus on multiple indicators across projects and countries is too diffuse.</p> <p>Testing the relative effectiveness and cost-effectiveness of different ILAs and training formats is lacking.</p>

## **2. BUILDING CAPACITY FOR TRAINING AND PERFORMANCE IMPROVEMENT**

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### **2.1 Building Capacity for Training and Performance Improvement**

This section reports PRIME's achievements in capacity building for both its training and performance improvement approaches. First, we report achievements in programs in which training is the principal intervention, although non-training interventions are often included to improve service provider performance. Secondly, we report the results of PRIME's Performance Improvement Approach (PIA) in which job performance is the primary focus and selected non-training and training interventions are designed to close performance gaps.

PRIME works with its partner agencies to build their capacity to plan, implement, and evaluate training. Typically, PRIME projects build local capacity in:

- training needs assessment;
- development of policies and standards;
- planning and managing training;
- training of trainers;
- development of training materials;
- project evaluation.

#### **2.1.1 Findings**

A recent review of capacity building in PRIME's worldwide activities showed that 11 projects are directly working to strengthen the capacity of developing country institutions to conduct training. In another 17 projects, at least some capacity-building activities are included. An example is the Auxiliary Nurse-Midwife (ANM) project in India. In this project, PRIME is developing capacity for training at multiple levels of 19 district health care systems. Teams of trainers have been trained in each district, and they are scheduled to train thousands of providers by the end of 1999. A summary of PRIME's accomplishments in each area of capacity building for training follows.

##### *Training Needs Assessment*

PRIME has conducted training needs assessment in 18 countries (contract target is 15). These assessments include information on the skills and knowledge of providers, their working environment, policies, and guidelines. The assessments do not, however, address adequately the job performance of providers, nor do they identify all of the non-training barriers to provider performance. As a result, the need for training is often over-stated. All providers are given the same amount of training, regardless of their performance level.

##### *Development of Policies and Guidelines*

PRIME has assisted in the development and adoption of performance standards in most of its

projects. These guidelines form the basis for increasing access to quality services and removing medical barriers.

### *Planning and Managing Training*

The primary intervention PRIME uses to improve the performance of service providers is classroom-based, trainer-led training. Training conducted by PRIME is state-of-the-art performance-based training, including participation, use of anatomical models for practicing clinical skills, based upon approved protocols and guidelines for service providers. USAID Missions, other CAs, and host agencies view PRIME training as high quality. Worldwide, PRIME has exceeded its targets for number of trainers trained, curriculum packages developed, and service providers trained.

### *Training of Trainers*

A major accomplishment of PRIME has been to decentralize training and to extend high-quality performance-based training into new areas of reproductive health and new levels of service providers. PRIME has prepared curricula, training manuals, and trained trainers for ANMs, ISMs, health attendants, and TBAs. Monitoring documents, evaluations of training results, and field observations by the evaluation team have shown that second and third generation trainers are delivering high-quality training adapted to the learning needs of their trainees.

A second major accomplishment of the PRIME training approach is that it has successfully built capacity for systematic follow-up and monitoring of training. Trainers routinely visit trainees in their work settings to monitor trainee performance. This follow-up provides information to trainers for improving training and data to program managers for program improvement. However, the follow-up visits we observed in India and Ghana were primarily focused on data collection and did not provide opportunities to motivate providers or help them identify and remove barriers to performance.

The major problem with PRIME's training programs is that, in reaching out to new cadres and new RH areas, much training and follow-up is staff-intensive, expensive, and difficult to sustain. In India, for example, training for ANMs is being delivered by two trainers for every four trainees. Follow-up visits are also very staff-intensive, often involving two-person teams spending as much time in follow-up visits as they spend in training. A safe motherhood project in Ghana is developing refresher training that will have six master trainers rotating training various sessions of ten-day courses for groups of eight trainees. These trainers have also spent several weeks developing a training manual and curriculum, much of which had already existed in other publications<sup>1</sup>. Training costs also include opportunity costs of trainees leaving their work sites for training, travel and per diem, and rental of training sites. PRIME is addressing the issue of training efficiency in part by introducing innovative training approaches (ILAs) to

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<sup>1</sup> It must be noted that PRIME does not determine trainer-trainee ratios alone. Decisions are made in conjunction with partner organizations which have their own implementation responsibilities and obligations, both within the project and elsewhere. These organizations make proposals for staff allocation and participation consistent with available resources.



reduce per-trainee costs (see following section 2.1.2).

Another opportunity for making training both more efficient and effective is pre-service training. PRIME has worked or is working in five countries (Paraguay, Yemen, Indonesia, Tanzania, and Morocco) to introduce FP/RH curriculum and improve training approaches into pre-service for service providers. PRIME is also working with the East Central Southern Africa College of Nursing to improve training approaches that will ultimately impact an additional 14 countries. To be fully sustainable, FP/RH knowledge and skills must be introduced as part of the preparation for all relevant service providers.

### **2.1.2 New Training Interventions such as Distance Learning, On-the-Job Training, Self-Directed and Interactive Technology**

PRIME has introduced a number of Innovative Learning Approaches (ILA) in selected projects to test more cost-effective training approaches, with emphasis on low-tech, sustainable training systems. PRIME identifies three areas in which it is testing new learning models:

- Integrated, multiple delivery systems such as distance learning and on-the-job training. An example is the distance learning activity in South Africa
- New technologies such as low-cost solar-powered tape recorders, self-directed learning modules, and radio-based instruction. District-level clinical officers were trained in Tanzania using a multi-media approach combining classroom training with cassette tape home study
- Traditional methods used in new ways or with new groups, such as the training of ISMs in India

PRIME has concluded that these ILAs have great potential for decreasing lost time away from the job for training, increasing learning achievement, and lowering cost per trainee. These benefits have not yet been fully demonstrated, although promising studies are under way in Tanzania, South Africa, Morocco, and Benin. These studies generally include a small number of trainees and do not compare ILAs with alternative methodologies in either results or costs.

The ILAs utilized by PRIME are appropriately low technology, suitable for the level of trainees and institutions with which it is working. For example, the distance learning initiative in Morocco is testing a paper-and-pencil self-directed learning package as an alternative approach for delivering in-service training for nurses and midwives.

### **2.1.3 Conclusions**

PRIME is increasing the capacity of its client agencies to conduct high-quality, performance-based training supported by skilled trainers, clear performance guidelines, training curricula and materials, and follow-up systems.

The vast majority of PRIME's activities are oriented toward developing capacity to conduct classroom-based, trainer-led training interventions. PRIME is requested to do these types of interventions by USAID Missions. PRIME has responded to these requests with state-of-the-art training approaches and high-quality, performance-based training. USAID Missions, host

agencies, and evaluation reports all indicate that PRIME has met and surpassed its targets in developing training capacity.

The major advance of PRIME in developing capacity in training is in institutionalizing systematic follow-up and monitoring of trainee learning and performance on the job. This capacity to follow-up training has enabled training organizations to maintain the quality of their performance. However, the follow-up of training does not adequately support trainees in identifying and correcting performance problems or in motivating them to improve performance.

The other major contribution of PRIME to training capacity building is in adapting and applying high quality, performance-based training to new reproductive health subjects (PAC, CPI, etc.) and to new cadres of reproductive health service providers (ISMs, ANMs, etc.).

PRIME is in the early stages of pilot testing a number of ILAs that have shown great potential for increasing the knowledge and skills of primary service providers in a more cost-effective manner. Most of these approaches have been attempted in pilot projects with small numbers of trainees. Evaluations of their effectiveness are still in progress. PRIME has not conducted studies of the cost-effectiveness of these approaches, nor has it conducted studies comparing the cost-effectiveness of alternative training delivery strategies.

Although PRIME has contributed strongly to the capacity of primary service institutions to provide quality training, the long-term sustainability of this training without outside support is questionable. While PRIME calculates the costs of its training inputs, the cost-effectiveness of alternative training approaches (including various trainer/trainee ratios, length of training, and innovative learning approaches) has not been studied for comparative purposes.

## **2.2 Performance Improvement Approach**

The Performance Improvement Approach (PIA) is a step-by-step, systematic methodology for performance analysis and change. It is based upon careful analysis of the performance gaps in a particular cadre of service providers, identification of the key causes of those performance gaps, and design and implementation of interventions to remedy the performance gaps. These interventions include:

- information, in the form of clear guidelines, protocols, and job definitions, and clear and immediate performance feedback;
- environment, including adequate and proper tools and workspace;
- incentives and motivation;
- organizational support in terms of strategic direction, leadership, and management and organizational structure;
- skills and knowledge needed to do the job effectively (Performance Approach Source Document: in draft).

The Performance Improvement Approach recognizes that training is not always the best solution for all performance problems; it is one of several interventions available for improving performance (Pepitone, James S., Future Training: a Roadmap for Restructuring the Training

Function, 1995, AddVantage Learning Press). The aim of PI is to select the interventions to close performance gaps that are the least costly and most effective. The methodology of improvement performance is well developed and tested, particularly in business and industry applications (Stolovitch, Harold and Keeps, Erica (eds), Handbook of Human Performance Technology, 1992, Jossey Bass).

In 1997 PRIME identified PIA as a promising approach and pioneered adaptations of the methodology for use in international FP/RH settings. Although many aspects of the approach have been incorporated into previous FP/RH performance-based training approaches, PRIME pioneered the full application of PI in this setting.

A typical PI application, as described by PRIME covers five stages:

1. Getting Project Agreement
2. Performance Needs Assessment
3. Design of Interventions
4. Implementation
5. Evaluation

PRIME's vision for PI is to develop sustained capability in national and local host country institutions to implement the performance improvement approach. PRIME believes that this capability will enable projects to become more results-focused (linking interventions with service results such as improved access and quality) and produce these results in a more cost-effective manner. PRIME has developed considerable internal expertise in the last three years to introduce this methodology. It is preparing and field testing a Source Document (PRIME's Performance Improvement Approach) and is presently conducting three pilot projects to determine its effectiveness:

- Dominican Republic: to improve performance of primary providers in the Social Security System
- Burkina Faso: creating improved performance of CBD workers in one district of the Directorate of Family Health/MOH
- Kenya: increasing training capacity in the Family Planning Association of Kenya

The PI project in Burkina Faso is illustrative. Under an unsolicited field support contract with the project, Santé Familiale and Prévention du SIDA (SFPS), PRIME set up a pilot project to demonstrate that the PIA can produce improvement in the performance of CBD workers. Following guidelines developed by PRIME/Chapel Hill and with technical assistance from Chapel Hill and regional staff, the project included the five steps of PIA:

**Step 1. Getting Project Agreement.** A series of meetings were held with key stakeholders, including project management, community leaders, and funding agencies. The meetings resulted in full participation and “ownership” of the performance improvement project.

**Step 2. Performance Needs Assessment.** A systems analysis of the CBD project in the community revealed that the performance was low (see figure in Appendix F: “The PRIME

Complete Systems Approach to CBD). The analysis revealed several key causes of the poor performance:

- Weakness in supervision
- Breakdown in logistics and re-supply
- Limited range of services provided
- Lack of community involvement in project management and monitoring
- Excessive reliance on external resources

**Step 3. Design of Interventions.** The stakeholder group identified appropriate interventions to address the causes of poor performance (based upon cost-effectiveness and sustainability). Responsibility for carrying out the interventions were assigned to the appropriate members of the stakeholder steering committee. The only intervention assigned to PRIME was training of supervisors.

**Step 4. Implement Interventions.** The prioritized solutions to performance problems were implemented by the appropriate stakeholder group, coordinated and managed by the steering committee. The principal interventions were:

- preparation and distribution of a start-up kit for CBD workers;
- development of a motivation and incentives package based upon revenues from sales of contraceptives and recognition for superior service;
- training for supervisors in “technical supervision.”

**Step 5. Evaluate Process and Results.** Early evaluation results of the Burkina Faso PIA project show that, compared to a control group, CBD workers receiving the above interventions significantly improved in their performance. These evaluation results are being disseminated to other projects and other countries, and a paper describing the project was presented by PRIME to the International Society of Performance Improvement (ISPI) Conference in March 1999.

### 2.2.1 Lessons Learned

Based upon the work done in the three pilot PIA projects, some valuable lessons have been learned about the application of PIA in PRIME:

- PI is a potentially powerful tool for linking training and non-training interventions to improve provider performance
- Pilot projects have been expensive due to heavy reliance on external expertise
- PIA tools need to be made more practical and accessible for field use
- Materials are needed to train PIA leaders and facilitators at the local level
- Existing training capacity (trainers, facilitation skills, training curricula and materials) can be utilized effectively in PI projects. Many of the competencies required to conduct PIA are the same as the skills and knowledge required of trainers (see Rothwell, William J., Beyond Training and Development: State-of-the-Art Strategies for Enhancing Human Performance, 1996, AMACOM)
- Natural linkages exist between Maximizing Access and Quality (MAQ) and PI as both deal

- with identifying the conditions that are necessary for increased access and quality
- Research is needed to determine the least costly combinations of interventions needed to achieve improved performance

### **2.2.2 Conclusions**

The Performance Improvement Approach is a powerful tool for assessing performance gaps, identifying cost-effective interventions, and linking interventions to individual and organizational performance. It is a methodology that has been widely applied in international business and industry, and has produced outstanding results. The PI approach has proven superior to the traditional training approach to performance improvement because it seeks to tie a variety of system interventions to performance and to find the quickest and least costly combination of interventions needed to produce improved performance.

The three PI pilot projects implemented by PRIME show promising results in improving performance and mobilizing and focusing the efforts of a variety of stakeholders in identifying and implementing solutions to performance problems. Other similar approaches, including AVSC's Whole-Site Training Approach have also shown impressive results (Bradley, Janet et. al., "Whole-Site Training: a New Approach to the Organization of Training, in AVSC Working Paper No. 11, August, 1998).

PRIME is developing tools for conducting PIA projects (including a Performance Improvement Sourcebook) and building capacity in its central and regional staff to conduct PI projects. At present, the tools are too complex and difficult for effective use by partner agency trainers and managers, who must be the ultimate implementors.

### **2.3 Recommendations**

1. PRIME should establish better linkages between training interventions and performance results by improving strategic planning for skills and strengthening the follow-up monitoring of service performance.
2. PRIME should increase the sustainability of its training approaches by finding the least costly, most effective approaches to training and performance improvement. Cost-effectiveness studies should be conducted to:
  - find more efficient ways to deliver classroom-based learning (student/instructor ratios, skill practice time, etc.);
  - compare alternative innovative learning approaches.
3. To make the Performance Improvement Approach a more useful tool for project personnel, PRIME should simplify PIA tools and materials and develop training curricula for PIA leaders. To the extent possible in the remaining project period, an effort should be made to test PIA in larger projects and in a greater variety of situations, perhaps by partnering with other agencies doing PIA-related work such as AVSC's Whole-Site Training Approach.

### 3. MAXIMIZING ACCESS AND QUALITY (MAQ)/ GLOBAL TECHNICAL LEADERSHIP

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#### 3.1 Maximizing Access and Quality: Findings

PRIME's major goal is to train frontline providers in expanded reproductive health services, working within both the public and private sectors. As stated in PRIME's document *Responses for the External Evaluation Team Scope of Work*, features of PRIME's MAQ strategy include:

- focus on essential primary personnel;
- integration of selected RH interventions;
- addressing provider needs and performance beyond training;
- policy activities;
- attention in training to counseling and other CPI skills;
- replicable and sustainable systems, approaches, and materials;
- culturally appropriate strategies.

The evaluation team found consistent evidence of PRIME's commitment to the MAQ goals and strategy throughout the organization. This includes the development of messages and information on MAQ from headquarters as well as incorporation of MAQ goals into all levels of program design at the field level. Field staff consistently reported satisfaction with communication, support, and technical assistance from headquarters.

To best evaluate the impact of PRIME's strategies on maximizing access and quality to health care, it was hoped that the evaluation team would have the opportunity to observe examples of service delivery from providers who had received training from PRIME in the MAQ approach. Unfortunately, due in part to the slow startup of PRIME mentioned earlier, few examples of measurable change in service delivery could be found.

PRIME's assistance in guideline review, revision, and dissemination has been key to building a strong base for creating high-quality training programs as well as in creating the institutional support for expanding the role of the primary provider. PRIME cites numerous examples of its role in providing technical assistance in guideline development which supports MAQ goals and strategies. An example of PRIME's TA in guideline development was seen in Ghana where state-of-the-art guidelines were in the final phases of printing and dissemination. Site visits found consistent approval of PRIME's role expressed by government agencies, as well as evidence of incorporation of guidelines and standards into all training materials reviewed.

PRIME's strength in dissemination of guidelines is probably greatest in its rapid incorporation into training materials and curriculum; however, dissemination through classroom training is too slow a process to reach all providers. Innovations, including dissemination through supervisory visits and on-the-job updates, need to be developed.

PRIME's definition of quality of care is stated as: "The provision of services which are accessible and readily available, acceptable, affordable, safe and effective; offered by competent and caring personnel, in appropriate conditions with the norms and standards established for the satisfaction of clients." Previous to the PRIME program, most training efforts were directed toward improving clinical services provided by doctors and nurses. A major achievement of PRIME has been its success in expanding access to services by greatly increasing the numbers and types of providers delivering services both in and out of the clinical setting. PRIME demonstrates this commitment by taking on the challenge of training non-traditional primary providers at the community level. The challenges inherent in this approach include overcoming professional resistance to expanding the role of primary providers, the sheer numbers of providers to be identified and trained, and the need to develop effective training for low-literacy trainees.

All program staff were committed to performance-based training of primary providers, combined with supervision and follow-up to yield the greatest results in improving the quality of and access to RH services for women at the community level. PRIME's expanded definition of primary personnel includes such groups as pharmacists, TBAs, CBDs, ISMPs, and midwife assistants. To date, PRIME has contributed to the RH skills and knowledge of more than 1,600 trainers and 330,000 service providers worldwide.

### **3.2 Lessons Learned and Best Practices**

Lessons learned and best practices include:

- development and application of practice protocols;
- inclusion of frontline providers in the process of guideline development, resulting in realistic and appropriate tools;
- training and preparing a core team of trainer supervisors to provide continuous monitoring and improvement of services;
- collecting data on provider practice norms and then giving feedback to raise providers awareness of their own biases and barriers to providing access to care;
- cyclic training modules which break down reproductive health issues into training packages thereby decreasing the amount of material to be absorbed in any given training activity as well as the time spent away from providing services.

### **3.3 Technical Leadership**

PRIME's technical, clinical, and programmatic contributions to the improvement of family planning, postabortion care, STI prevention, and maternal health have been significant. PRIME's mandate recognizes the reality that women need to access care in their own communities, from known providers with whom they have already established a relationship of trust, and that services must be provided in an integrated fashion that acknowledges the interrelated nature of reproductive health needs.

Though still in the early stages of program development, the expansion of PAC and LSS capabilities to the community level will allow women who previously were unable to obtain life

saving services due to limitations of transport or resources to receive timely treatment. The provision of these services at the community level also guarantees the opportunity to offer follow-up services including STI education and family planning. PRIME's emphasis on FP counseling, informed choice and consent, and multiple method mix has the potential to greatly increase contraceptive utilization, removing many hurdles to previously stagnant prevalence rates.

### **3.4 Significant Accomplishments and Lessons Learned**

- PAC/LSS services can be learned and delivered by a much broader range of providers.
- Guidelines have been revised to integrate PAC/LSS and STI/HIV in RH services.
- Client-oriented provision of FP including counseling for informed choice and method mix improves quality.
- Cadres of FP/RH providers expanded.
- Frontline providers can effectively expand services without loss of quality.

### **3.5 Grist for the Mill**

Although the evaluation team found the PRIME program to be very strong in principle, a number of weaknesses were observed at the level of implementation. The following observations are included as examples and are not meant to be a criticism of any individual program. They are presented instead to illustrate how difficult it can be to “translate” PRIME theories into practice as well as to add to our “lessons learned along the way.”

In one project visited, though MAQ concepts were well incorporated into the design of TBA training, it was not clear that enough attention was paid to the actual selection of TBAs to be trained. It was observed during this evaluation that seven of the ten “TBAs” in training were actually “cord cutters.” (Of 2,065 TBAs trained in three districts in India, 296 (14 percent) were cord cutters.) That is, they were women whose role was clearly limited by caste to cutting the cord after the birth of the placenta and cleaning up after birth. These women have limited responsibility for antenatal care, birthing, or postpartum care of the mother, although they learn what postpartum danger signs to observe and if the patient should be referred for life-saving assistance. The resources for that particular training were therefore largely wasted as well as guaranteeing that outcome indicators for TBA training are unlikely to yield improvement. PRIME is evaluating this issue and expects the results to reveal whether training is actually helping cord cutters to expand their role.

In addition, TBAs complained of a loss of revenues after training due to the erroneous perception by the community that the TBAs were now government employees and therefore receiving a salary. This points to a lack of community preparation for the intervention. Also, there was some evidence that the TBA training included outdated information, such as encouraging women to lie down during labor and delivery, or cutting the cord before delivery of the placenta despite a strong cultural bias against this unnecessary procedure. Finally, the curriculum had not yet been re-translated into English to recheck accuracy of content.



Another program had insufficient essential supplies available post-training, creating a gap between training and practice. The result of such poor planning can be wasted training resources.

Supervision is not always seen as a tool to improve job performance. A senior CBD supervisor reported chastising CBD workers who did not perform to the standards of the checklist and saw more training as the needed remedy to poor performance.

### **3.6 Conclusions**

PRIME's goal of reaching frontline providers to improve quality and access to services is the missing link in previous development attempts to improve health services, but the pursuit is a difficult one at best and will require innovation, efficiency, and time.

PRIME's limited definition of its technical advisory role may foster a "disconnection" between PRIME's goals and the reality of PRIME's effectiveness in the field. That is, once PRIME has provided technical assistance (TA) in curriculum development, training, or supervisory systems, it often takes a "hands off" approach, encouraging partners to take a major role in implementation. While fostering local capacity building, this strategy sometimes leads to inadequate or inappropriate monitoring of the progress of initiatives in the field. More time and attention is needed in overseeing program implementation to detect and remedy problems early.

PRIME needs to shift its focus from the development of complex theoretical models to finding what works in the field. PRIME's Performance Improvement Approach has the potential for achieving this goal. The challenge will be to present this tool as a simple, user-friendly model.

The lessons learned and best practices listed in section 3.2 above are found in a sampling of PRIME projects and need to be incorporated as the norm into all PRIME programs.

### **3.7 Recommendations**

4. PRIME should intensify efforts to move from training intervention to results orientation and strengthen linkages between training and measures of performance at service levels.
5. Greater emphasis is needed on follow-up and supervision at the field level to change old patterns of dogmatic service delivery and authoritative supervision.
6. PRIME should develop leadership capabilities among primary providers. Efforts should be made to identify and recruit those individuals who show promise and provide them with training and support in leadership and management skills.

## 4. CAPACITY BUILDING, INSTITUTIONALIZATION, AND SUSTAINABILITY

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### 4.1 Findings

#### 4.1.1 Sustainability and Capacity Building

Increasingly, PRIME has adopted more and more elements of the Performance Improvement Approach as it works to operationalize capacity building. PRIME attempts to strengthen capacity at all stages of project development, from initial negotiations through to evaluation. In programs in which PRIME has a substantial role, staff work with counterparts to develop long-range strategic plans with objectives and benchmarks, ensuring local commitment and resource allocation. Efforts are made to develop monitoring materials to self-evaluate the planning and implementation process. Wherever feasible, the training focus is shifted from improving knowledge and skills to performance improvement, and managers are guided in improving human resource recruitment, development, and deployment.

#### **PRIME's Definitions of Capacity Building, Institutionalization, and Sustainability**

**Capacity Building in Training:** The process through which organizations **enhance** their technical capabilities, resources, infrastructure, and managerial systems, in appropriate community and policy contexts, to conduct effective training for improved provider performance, service access, and quality.

**Institutionalization of Training:** The process by which an organization **incorporates** training, resources, infrastructure, and management systems to produce improved provider performance, service access, and quality.

**Sustainability in Training:** The ongoing capacity of an organization in **the provision of inputs** and generation of resources for improved training, provider performance, service access, and quality.

Examples from India, Mexico, and Tanzania illustrate the comprehensive strategies undertaken to develop the skills needed to plan, monitor, manage, and document training programs. In India, ANM Regional Health and Family Welfare Training Centers have reinforced their ability to implement training programs at different levels in the district, and provide a model being considered for replication elsewhere in the state of Uttar Pradesh. The IMSS (Mexican Social Security Institute) activities in Mexico have used a client-centered approach and trainer networks to re-invigorate a moribund training strategy; it is targeted for national expansion. The Tanzania experience grows from a detailed, interlocking strategy that includes development of policies and guidelines; development of a national training program in the Ministry of Health guided by a national training strategy and supported by national curricula and materials; and changes in supervision approaches and tools. Pre-service training, launched in 1996, further strengthens the

foundation for improved performance by providers.

Pursuit of a more strategic, systems orientation to training brings to light a new array of skills required by program personnel. Managers need to develop planning skills, and familiarity with project planning tools. For example, project planning software is available to develop timelines, plot resource allocations, and develop relations among program activities. Managers must have staff available to use such tools, and must themselves be able to interpret long range plans and use planning output for decision-making. While field visits showed some evidence that such skills are being developed, and indeed adapted for other applications or departments (State Innovations in Family Planning Services Agency (SIFPSA) in India), the team saw other cases in which even routine monitoring reports are not being used for data-based decisions.

PRIME has no systematic program for leadership development, for example through fellowships or long-term training of host country counterparts. They are not required to do so contractually, but were asked by USAID to explore this issue. A broader focus on development and strategic management of training programs may yield suitable candidates for such a program in the future.

#### **4.1.2 Index of Capacity Building Indicators in Training**

PRIME is developing an “Index of Capacity Building Indicators in Training” to help define current training capacity; to prioritize essential training components; and to permit comparisons across time and among regions, countries, or institutions. The index has five main variables (Legal Policy, Resources, Training Plans and Curriculum, Organizational, and Community Development and Participation) with sub-indicators. Each of the 21 indicators is scored and standardized. Plans call for modifying and using the index, refining it, and including it in upcoming baseline assessments or evaluations.

While the evaluation team recognizes that it is useful to have a tool to assess the local training needs, it is not convinced that substantial effort should be devoted to developing this index. The team questions the feasibility of actually applying the index. It is complex, relying on too many variables. It is difficult to score, particularly using qualitative assessments, and scoring may be arbitrary; and it is difficult to interpret when so many indicators are combined in one index. How are the individual indicators weighted in the total? Does achievement of a high score imply graduation from the need for additional support or technical assistance?

#### **4.1.3 Collaboration with In-Country Institutions**

PRIME project staff see their capacity building TA as a cyclical process including negotiation, design, needs assessment, implementation, monitoring, and evaluation. Efforts are made at all stages to fully involve local institutions, and to agree upon key roles and responsibilities for all partners. Host country partners participate in project design, and in selecting interventions, sites, and approaches. They collaborate in conducting needs assessments and in interpreting results. Often needs assessments highlight impediments to service delivery best addressed through non-training interventions, and host country institutions assume responsibility for correcting them.

During implementation, PRIME works with local institutions to develop the planning and

management skills needed to carry out training programs. The project also helps to develop supervision systems. To the extent possible, the project works with the existing infrastructure and procedures, preferring to strengthen existing systems rather than introducing new ones. If existing systems are dysfunctional or inefficient, PRIME assists with development of new ones. PRIME views its role as providing guidance to build skills among implementing institutions. To the extent possible, staff work as motivators and facilitators, rather than as implementors.

An example of comprehensive capacity building strategies can be seen in the work carried out in India. There, PRIME is working to enhance technical capacity, infrastructure, and management systems.

*Enhance technical capabilities:*

- Conduct needs assessment to develop or refine training curriculum
- Develop performance-based training curriculum
- Enhance effectiveness of the use of training with innovative learning approach
- Develop a cadre of skilled performance-based trainers
- Follow-up at the work site to improve performance and provide supportive supervision

*Enhance resources and infrastructure of implementing agencies:*

- Training site assessments
- Work site assessments to strengthen service sites
- Technically skilled service providers to provide quality services
- Use of participatory methods to enhance community participation (Community Partnership for Safe Motherhood in India)

*Enhance management systems:*

- Planning and management of training
- Development of MIS
- Enhancement of supervisory skills
- Periodic monitoring, evaluation, and documentation

#### **4.1.4 Strengths and Limitations of PRIME's Country Strategic Training Plans**

**Strengths:** Training plans are strong in tracking progress, through a detailed work plan with all component tasks enumerated, proposed or actual activity dates listed, training and materials development participants identified, and trainers or consultants named. Accomplishments are tracked against the project plan, and completed activities are linked with relevant trip or other activity report numbers. Activities are linked with USAID/Washington or field Missions' Strategic Objectives.

**Limitations:** The training plans reviewed by the evaluation team cannot be fully considered as "strategic" plans. They did not describe the needs of national training systems; rather they listed the interventions to be undertaken by the PRIME project and its partners, without mention of

how these activities supported or complemented programs under way with local or donor support. The plans do not identify alternative training models or costs of alternative training options. Participant and site assessments provide valuable information that has been used to improve participant selection, training curricula, and service delivery sites, but assessment results were not always used to rationalize training opportunities.

#### **4.1.5 Collaboration with Local Counterparts and Other CAs**

PRIME was consistently cited by local counterparts, CAs, and USAID Missions as fully and collegially collaborating in project design and implementation. Among the examples noted are: work with JSI, Pathfinder, and FHI to adapt global training modules to individual country applications; work with FOCUS on Young Adults (Pathfinder) on activities targeting adolescents in Ghana, El Salvador, and possibly Indonesia; support of the Spanish and French translations of a poster accompanying a recent Population Report on “Care of Post Abortion Complications”; and work with the Delivery of Improved Services for Health (DISH) Program (Pathfinder) in Uganda to train midwives in PAC.

PRIME shares offices with JHPIEGO in Indonesia, where the projects collaborate closely to develop an in-service curriculum for midwives, and national RH standards and guidelines. In a number of countries, including India, Tanzania, and Peru, PRIME staff meet regularly with other CAs to plan activities and resource allocations. Increased USAID Mission focus on Strategic Objectives (SO) is forcing CAs to jointly plan activities to meet Mission goals. In some cases, however, USAID needs to take a more active coordinating role.

Project staff identified potential incentives for better collaboration:

- Develop opportunities for joint programming
- Identify common objectives and goals
- Engage in annual planning sessions
- Share performance indicators
- Share reporting requirements for routine monitoring
- Plan joint evaluations to allocate attribution for improved performance and services
- Clarify roles among collaborating partners
- Reward flexibility, perhaps through line item flexibility and/or increased Level of Effort (LOE)

#### **4.2 Conclusions**

While many elements of the training system (materials, curricula, and trainers) are well developed to contribute to capacity building, and the process of project design and implementation may contribute to institutionalization, sustainability of many training systems remains vulnerable. In particular, emphasis on systems approaches and performance improvement demands that greater attention be paid to the development of planning and data for decision-making skills.

### **4.3 Recommendations**

7. PRIME should increase the emphasis on developing training program management skills, including program planning, financial resource allocation, human resource recruitment and deployment, and timeline preparations. PRIME should utilize commercially available software with the potential for spin-off applications in other RH domains.
8. PRIME should test the applicability of the Index of Capacity Building Indicators in Training in three sites and assess the utility and comparability of the results to determine whether the Index is a useful tool. If yes, complete final adaptations and prepare a technical report for circulation. If no, suspend further work on the Index.
9. PRIME should convene a working group among CAs, or draft a document for circulation among CAs, detailing feasible strategies and incentives for collaboration. This document should be submitted for discussion with the USAID PHN Center.



## **5. MONITORING AND EVALUATION**

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### **5.1 Findings: Evaluation**

PRIME evaluates project progress, outcomes and impact through several types of activities:

(1) Technical assessments of particular program conditions such as provider profile characteristics, level of infrastructure or equipment needs of facilities, community perceptions of the need for a specific health services, training needs of a service delivery organization, characteristics of a particular service delivery strategy, or gaps in supervisory system. The Diagnostic Assessment of Performance Potential (DAPP) approach developed by the PRIME project is a type of technical assessment. In addition, the Performance Improvement Approach (PIA) developed by the PRIME project also utilizes the baseline needs assessment as well as post-intervention evaluation as part of its methodology.

(2) On-site project reviews examine project activities, accomplishments, and indicators to determine whether a project was implemented as planned, and identify problems and solutions for remedial actions, if appropriate.

(3) Special studies or research provide in-depth information about the outcomes and impact of PRIME interventions. The project completed 10 Operations Research (OR) studies by the end of 1998 and expects to complete another eight by December 1999. Some studies have used quasi-experimental designs (e.g., Planned Parenthood Association of Ghana (PPAG) supervisor study in Ghana; the Pharmacy/Pharmacy Agent Training Study in Benin), while others have used both qualitative and quantitative surveys, rapid assessment, or situation analysis approaches. Both special studies and the technical assessments mentioned were summarized in technical reports for dissemination. Special studies and OR include studies to:

- determine increases in new contraceptive acceptors;
- enumerate new private and public sector FP/RH services sites;
- identify the number of service providers capable of offering a choice of contraceptive methods;
- explore reasons for continuation/discontinuation of FP services;
- assess client satisfaction and quality of services (e.g., quality of CPI);
- determine the extent to which provider knowledge and skills are improved through training (pre-test/post-test studies);
- study the adequacy of new training methodologies, technology, and materials.

(4) PRIME conducts pre-test/post-test surveys of knowledge and assessment of skills before and after training sessions. In addition, follow-up studies (usually four to six months after the training) are conducted to assess whether knowledge and skills are maintained after the training ended and to assess whether the skills are actually being used in the workplace. Checklists and observations of client-provider interactions are used to assess improvements in counseling skills and the quality of care provided.



## **5.2 Conclusions**

Evaluation indicators and monitoring instruments designed by PRIME staff are not always used. When monitoring and evaluation data are collected, the data are frequently not fully analyzed nor utilized for program planning, decision-making, and performance improvement. PRIME's system for tracking and measuring progress and achievements of results can be strengthened by:

- allocating more resources in staff time and money for monitoring, evaluation, and research activities to better document results. This will help to ensure that the highest quality data are collected; reduce delays in reporting, analysis, and write-up of study reports; and timely dissemination activities. New staff in Latin America and Bangladesh should be in place and oriented soon to avoid delays in conducting monitoring and evaluation activities;
- simplifying and reducing the number of indicators and checklists used in monitoring and evaluation activities. The project should adopt a limited number of process, outcome, and impact indicators that are used to effectively monitor progress toward achieving the strategic objectives, intermediate results, and sub-results defined in the results framework;
- avoiding development of too many different kinds of models and indexes, especially those that have unduly heavy data collection requirements. The project should focus on only one or two to put forward for field-testing (e.g., the PIA);
- scheduling regular visits of field monitoring and evaluation staff to headquarters, and headquarters monitoring and evaluation staff to the field to discuss data issues; standardizing procedures across regions; and providing TA in the design and implementation of baseline assessments, final evaluations, and special studies. The regional evaluation staff who talked to the team during this evaluation expressed satisfaction with the technical support now being received from the Evaluation and Research Unit (ERU). The staff of the ERU could act as mentors to the monitoring and evaluation staff in the regional and country offices, and help to ensure higher quality research and more standardized procedures in evaluation designs and reports prepared in the field.

## **5.3 Significant Project Results in the Evaluation and Research Unit**

The number of completed evaluations and special studies over the past four years has been limited and delayed, due in part to delays in the approval and implementation of training interventions and also to a lack of sufficient evaluation and research staff at headquarters and in the regional offices. In addition to 18 special studies and operations research in the various regions, evaluations were programmed for PRIME interventions conducted in more than 20 countries. Evaluation activities of capacity building efforts have been under way for some time. However, evaluations of some of PRIME's key result areas (e.g., CPI, PIA, IRH, and PAC) have only recently begun and few if any of these evaluations have been completed. The PIA initiative has only recently been piloted in three countries and thus it is too early to report on the success of this approach. The evaluation of the impact of implementation of national guidelines in Ghana (being conducted by FHI) has been slowed by delays in the dissemination and implementation of the national guidelines, in part due to the MOH shift in the content of the

guidelines from a primarily family planning focus to one that incorporates a broader range of reproductive health issues.

A few examples of some significant project results that have been documented through PRIME research and evaluation activities include:

- a study of the impact of training on family planning service utilization in Tanzania showing a significant positive impact of training on the number of new family planning acceptors at the clinics, even after controlling for socio-demographic (e.g., age and education of client) and other programmatic factors (e.g., Information, Education, and Communication (IEC));
- pre-post training surveys of knowledge and skills conducted in Ghana, India, and other countries showed significant increases in the skills of trained providers. In Ghana it was also found that training increased supervisory knowledge and skills competencies immediately after training. The Ghana PPAG evaluation of training of CBD supervisors showed that part-time supervisors were as effective as full-time supervisors of CBD providers in Ghana, which had enormous cost-saving implications. The results of the PRIME evaluations have been used as a basis for scaling-up training activities of FP/RH providers in state-wide (e.g., Uttar Pradesh, India) or national programs (Ghana);
- the Jhansi District Health Sub-center Assessment in India found that health sub-centers had serious deficits in equipment, supplies, and facilities, and the vast majority of the centers had no private rooms for IUD insertions or counseling. Findings were used to prioritize ANM selection for training and to identify ways to upgrade clinic conditions to help ensure success of training and service delivery at those sub-centers;
- a follow-up study of ISMP training in non-clinical FP methods in India conducted three months after training found a large increase in the proportion of ISMPs providing FP services after training and noted that at least two of the three critical skills for which they received training were effectively retained;
- a study of pharmacist FP/RH counseling training in Benin which showed substantial improvements in the quality of pharmacists' counseling skills, the information provided, the privacy afforded the client, and their positive interactions with the clients;
- evaluations and studies in Latin America showed post-training improvements in CBD promoter effectiveness (Nicaragua), improved quality of care in rural settings (Peru), and improved FP and PAC skills (Brazil).

The PRIME technical reports series and the January 28, 1999 document prepared by the ERU entitled "PRIME Evaluation and Special Study Technical Reports Inventory (by Region)" provide detailed information on the topics, objectives, study designs, and results of specific evaluations and special studies.

While there is little time left in the present project, there are a number of evaluations planned or under way: a qualitative study of discontinuation in Togo; pilot testing of the PIA in three countries (Burkina Faso, Dominican Republic, and Kenya); a comparative study of CBD training in Burkina Faso and Benin (population baseline survey data have been collected by the London School of Hygiene and a follow-up survey is also planned in project sites in both countries); an evaluation of the Ghana Registered Midwives Association activities in Ghana; evaluation of the community partnership for safe motherhood (CPSM) project in India; and follow-up performance evaluations of trained TBAs, nurse-midwives, and traditional practitioners in selected countries.

A number of important interventions began during late 1998, and may not be ready for a final evaluation of outcomes and impact. Results are expected in 1999 concerning SDL/CPI training, the PIA in three countries, IRH training, and LSS/PAC training.

The ERU received financial support in late 1998 from the Evaluation, Documentation, and Dissemination Initiative (EDD). Under EDD five consultants (one in each region) and a research documentation specialist at PRIME headquarters will work with PRIME evaluation to prioritize and finalize key evaluations and special studies, write-up final evaluation reports, and help disseminate results. The Program Development Management Unit (PDM) and the ERU met while this evaluation was under way to set priorities on completing project evaluations and special studies and to plan for the dissemination of findings.

## **5.4 Research and Evaluation Staff**

### **5.4.1 Findings**

The recent recruitment of two well-qualified research and evaluation specialists (an MD/Ph.D. in medical demography and a Nurse/Ph.D. in anthropology) has substantially strengthened the ERU which previously had only one staff member, whose time was divided between evaluation and PI activities. These staff should provide support to the regional offices in monitoring and evaluation activities and special studies, and continue to develop appropriate methodologies for evaluating training interventions and streamlining the data collection requirements. Full-time evaluation staff and evaluation consultants should be in place in each region so that final evaluations, including data analysis, write-up, and dissemination of project results can be completed as soon as possible.

Regional evaluation specialists are responsible for overseeing research and evaluation activities for project interventions in their respective regions. Evaluation and research staff at PRIME headquarters provide back-up support on issues of research designs, implementation of studies, and analysis, report writing, and dissemination, and they ensure some standardization in study designs, indicators, and data collection instruments used for interventions conducted in more than one country or region. In addition to monitoring progress and reporting on evaluation results relating to the original PRIME objectives and contract deliverables, evaluation specialists in the regional and country offices also need to be responsive to the USAID Missions' need for specific data and indicators linked to specific SOs and IRs, and sub-results. At the same time, PRIME evaluation and research staff in North Carolina often must be responsive to USAID/W's

need for sometimes different evaluation results and indicators.

#### **5.4.2 Conclusions**

The relationship between headquarters and field staff working on evaluation can be further strengthened by closer communication; more frequent field visits to mentor field research and evaluation staff to assist them in the study design and analysis, and to help them ensure quality and comparability of field data collection; and in the dissemination of study findings.

#### **5.5 Disseminating Research and Evaluation Results**

PRIME has produced and printed nine technical reports which are available in the Evaluation and Research Office and in the INTRAH library, and on the INTRAH website at [www.intrah.org](http://www.intrah.org) (by clicking on the PRIME logo). Some PRIME technical reports are also available on the Ipas and PATH websites.

The *Diagnostic Assessment of Performance Potential (DAPP)* was distributed through an INTRAH mailing. Evaluation materials have been displayed and distributed at conferences such as the American Public Health Association (APHA) and the Global Operations Research Conference on Improving Reproductive Health Programs sponsored by the Population Council. Presentations of results were made at APHA Meetings in 1997 and 1998; to USAID/Washington in 1997 and 1998; at NCIH Meetings in 1998; and at USAID/Missions and CA Partner Meetings. Three PRIME reports were contributed to the Task Force on Communicating Research Findings in preparation for the NGO forum at ICPD+5 1999 Meeting at The Hague in February 1999.

Many of the evaluation studies that have been completed have not been written up and disseminated properly. Consequently, the key messages, results, and success stories based on the project evaluations and special studies have not been effectively communicated and utilized in many cases. Furthermore, very little time remains in the PRIME project to complete the outstanding studies and evaluations and to disseminate the findings.

#### **5.6 Recommendations**

10. Study results and technical reports that detail project accomplishments and lessons learned should be more widely disseminated to CAs, and to USAID Missions, regional offices, and training organizations.
11. Research and evaluation dissemination topics should be included in planned end-of-project workshops. The most significant results presented at the workshops should be presented at the final project dissemination seminar.



## 6. PUBLICATIONS AND DOCUMENTS

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### 6.1 Findings

During the visit to PRIME headquarters in Chapel Hill, the evaluation team reviewed a wide variety of PRIME documents and publications (see Appendices C and D for lists of reviewed publications).

PRIME documents can be divided into two main categories, global and regional materials and country-level materials. Of the first category, the major efforts have been directed to the development of three publications that are reviewed below:

1. *Reproductive Health for Primary Providers: A Sourcebook for Curriculum Development*. Three of the eight modules in this guide were reviewed and “walked through” using possible field scenarios with the help of Cathy Murphy. The Sourcebook appears to fulfill its goal of providing a basic resource for integrating reproductive health as well as the concepts of CPI into new or existing curricula without duplicating previous efforts. The publication has been widely distributed with more than 1,100 sets being used in more than 28 countries. Responses to the usefulness and usability of the resource are mixed but generally positive.

2. *The Menstrual Cycle and Its Relation to Contraceptive Methods: A Reference for Reproductive Health Trainers*. This is a self-study manual, which relates the way contraceptive methods affect and are affected by the menstrual cycle. The publication fills a gap in information for trainers and providers. Now translated into Spanish and French, it presents complex and often difficult material in a clear and user-friendly manner. It should prove to be a valuable resource.

3. *Recommendations for Updating Selected Practices in Contraceptive Use*. PRIME collaborated with the MAQ Technical Guidance/Competence Working Group (TG/CWG) in the development of this resource. Collaborators also included the Department of Epidemiology, UNC; USAID; IPPF; Pathfinder International; WHO; FHI; and MSH. A quick review of its contents shows that the guide provides an essential baseline for standardizing contraceptive use and eliminating medical barriers.

During field visits the team observed that PRIME publications and documents were being used extensively, many having been adapted and included into curriculum materials for a variety of reproductive health subjects. PRIME also makes good use of materials that have been developed by other organizations, including JHPIEGO. Little duplication of effort was noted.

The biggest problem noted in the application of publications is that many are complex, unwieldy, and not user-friendly. The language level of some documents is difficult and many overwhelm the user with a plethora of instruments and checklists. For example, a PRIME-produced manual for CBD workers in Ghana (Technical Supervision Protocols for Community Based Reproductive Health Services) contains 12 instruments and 18 protocols and checklists. The CBD supervisor judged the publication to be “too bulky” and said he only used one of the checklists in his work.

PRIME has produced an enormous number of documents, studies, reports and evaluations, yet the “story” of PRIME’s accomplishments has not been adequately communicated. As a representative of a USAID CA stated, “PRIME has not carved a niche. It isn’t visible. It doesn’t tell its story.” PRIME is aware of this problem and has developed a dissemination plan for the last year of the project.

## **6.2 Conclusions**

PRIME publications fill an important niche by providing materials for the development of more specifically targeted publications, thereby eliminating duplication of effort and improving quality of locally produced materials; however, many materials require a high level of education or training in order to use them easily, particularly *The Sourcebook*. Future publications could include updating and improving PATH’s publication on developing materials for low-literacy audiences and in creating a software template for curricula based on field studies of user-friendly formats.

Number and complexity overwhelm many of the end users of the PRIME instruments and checklists. Also, the language level of many of the manuals and instruments makes them difficult to use. A useful way to deal with the proliferation of instruments and checklists is to prepare guidelines for training that are complete and detailed but prepare checklists for monitoring and field use that are abbreviated and include essential steps only. JHPIEGO has distinguished between training guidelines and monitoring checklists. Checklists should be published in a more accessible and durable manner such as one-page, plastic-laminated job aids that can be carried by field personnel under difficult working conditions.

PRIME has not adequately told the story of its accomplishments, successful innovations, and lessons learned. USAID Missions, international agencies, other contractors, and the larger community of health care professionals need information presented in a usable and attractive format. PRIME should dramatically increase its communications, both internally and externally, about accomplishments and lessons learned. Simple and attractive written presentations using identifying colors and logos and presentations in professional fora and regional conferences should tell the story in a compelling fashion. Publications that should be considered include:

- a newsletter that highlights useful ideas, success stories, and best practices;
- simple, attractive bulletins that describe useful training and technical innovations (a good example is the two-color, two-page handout called “PRIME’s Performance Improvement Approach”);
- synopses of evaluation studies and other documents that highlight lessons learned.

## **6.3 Recommendations**

12. PRIME should continue to focus its efforts on publications that can serve as templates for materials development particularly at the primary provider level. As part of this process, PRIME should simplify many of its instruments and checklists and eliminate those that are not useful to field personnel.

## **7. MANAGEMENT**

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### **7.1 Effectiveness of Organizational and Management Structure**

#### **7.1.1 Findings**

The early management of the project was inadequate to optimize partner inputs. After its reorganization, PRIME strove to enhance partner inputs through concerted and deliberate investments in team building. Each partner is now responsible for a key result area, with representatives of other partners on technical committees: PAC (Ipas, INTRAH); CPI (INTRAH, PATH); PI (TRG and INTRAH); and IRH (ACNM, INTRAH). A senior member of each partner is on the program committee, charged with maintaining focus on the “big picture” of the overall program. Three partner staff are housed at INTRAH, plus the Latin America and Caribbean (LAC) regional director is a PATH employee. Secondments serve several beneficial functions:

- Making management of implementation easier
- Easing access of the field to technical strengths of partner organizations
- Facilitating communication

Partners meet quarterly for routine staff and technical meetings; quarterly to review progress on workplans, and toward achieving results; and annually for a participatory “Decision Day” to approve activities and decide how core funding is to be spent.

Project structure has evolved in part in response to field realities in which technical issues are more complex than they were only five years ago, following shifts in orientation that emerged post-Cairo and Beijing. Management of the project is high maintenance, both for project staff and for USAID. It is time-intensive to maintain full communication with partners and field offices, and a challenge to respond to the diverse requests of USAID missions and host country counterparts; however, this structure makes technical expertise with multiple skills and a variety of implementation strategies available to the field. Common technical themes pursued globally help keep activities consistent and organized.

During the first two years of the project, key senior management positions were not filled. In other cases, there was an inappropriate match of job responsibilities and the staff person’s skills. Virtually all senior staff positions, including the Executive Director and the Directors of Research and Evaluation, Performance Systems and Instructional Technology, Communications and Development, and Program Development and Management, were hired late in Year 3 or during Year 4 of the project. (The PMD director’s position existed and the incumbent was replaced. The position of Director of Instructional Technology also existed; the position description was expanded to include performance systems and a new director hired.) As a result, staff focused limited attention on key activities such as evaluation and dissemination of project results, and are now hard pressed to carry out and complete important documentation efforts before the end of the project. (A partner group meeting was scheduled during this evaluation period to prioritize the 1999 work plan.)



### **7.1.2 Conclusions**

PRIME and USAID staff agree that the new organizational and management structure, coupled with additional technical staff, has enhanced the ability of the project to respond effectively to the diverse needs of a global project. Headquarters, regional and partner staff, and USAID collaborated to develop an integrated structure with nearly seamless participation among five partner organizations. This has increased and facilitated access to the technical strengths of each partner by USAID field missions and host country counterparts. Partners are fully engaged in strategic planning and reviewing results, and there is transparency regarding project resources, fostering group equilibrium.

## **7.2 Field Offices' Relations with Headquarters**

### **7.2.1 Findings**

PRIME has four regional offices, in Kenya, Togo, India, and the Dominican Republic. There are full or part-time staff in at least nine other countries. The relation of regional offices to country offices varies according to program needs. For the regional office of Asia and the Near East (ROANE), regional staff work with local USAID Mission and country counterparts to plan PRIME's program and begin implementation, while identifying country staff to gradually assume technical implementation and management. Regional staff establish the country office, and work with each office to ensure proper financial and administrative management, as well as a thorough understanding of the PRIME approach in improving provider performance.

The project demonstrates multiple strengths of a decentralized approach:

- Country activities are field driven
- Field response is rapid
- Regional offices are flexible in adapting to changes imposed by field realities.
- Staff have firsthand knowledge of health care systems in the field
- Staff are able to keep abreast of changing regional priorities in IRH and SM
- Offices supplement staff with local consultant pools, particularly in West Africa.
- Local collaboration with other CAs is facilitated
- Regional staff are able to personally negotiate with USAID Missions and host country counterparts and to manage field support resources
- Field staff are dynamic and well respected, with cultural and language agility
- The project is recognized for its meticulous planning, helping to underscore to both USAID and host country counterparts that many processes linked with training, such as selecting, upgrading, and equipping clinic sites or follow-up supervision, take time

Likewise a decentralized approach also faces implementation constraints:

- Detailed review of field support proposals takes time (The process can be streamlined by limiting the number of reviewers, use of a concise checklist for technical reviews, strict time limits on review turnaround, e.g., one week)
- There are limitations on contracting, field clearances of proposals, consultants, and funding

authority

- Staff are overextended, as regional staff run country programs from regional offices (for example, Ghana and Benin)
- Effort must be made to maintain steady communication to ensure regional office staff are up-to-date with USAID/W expectations and changes in HQ and partner staff and areas of expertise, and that they have the information needed to be open to new ideas that can be integrated into country and regional projects
- New reporting and documentation systems and procedures must be developed to facilitate communication and dissemination

### **7.2.2 Conclusions**

Field visits, Mission e-mail replies, and discussions with local counterparts confirm that field offices are advantageous in relating to clients. Nevertheless, administrative and contracting procedures frequently slow responsiveness, and reduce local decision-making authority. Streamlining review procedures and developing more budgetary autonomy would contribute to enhanced flexibility and responsiveness to local requests.

## **7.3 USAID Management**

### **7.3.1 Findings**

Relations with the Communications, Management and Training (CMT) Division are good. The project collaborates with the Senior Technical Advisor to jointly determine work tasks. PRIME acknowledged its need to recognize CMT as a client, with its own distinct needs separate from those of field missions. For the most part, PRIME responds to guidance provided by the Office of Population. Given the changes in USAID structure and emphases and to changing field priorities, there is a growing awareness of potential links with the Office of Health and Nutrition (HN). To date, such links appear to be underutilized. PRIME shares reports with HN on strategic approaches, countries with which it works, and objectives, but not on what is actually accomplished in specific settings.

Relationships with field Missions are cordial and respected; Mission responses to a global survey expressed satisfaction with project responsiveness and performance. PRIME field office staff interviewed also noted largely supportive relationships with USAID Missions in countries in which the project is active. What is more problematic is reconciling USAID/Washington emphasis on key results with field priorities. For example, while USAID/Washington encourages the project to be innovative in using alternative learning approaches or curriculum content, missions are often loathe to use field support to underwrite experiments. “New and innovative” are often viewed as “untested and untried.” India presents what is probably a common reaction. The Mission is receptive to innovations if they are perceived as “value added.” If the Mission were approached to be an experimental site, it would require convincing evidence that the innovation would truly make a strong contribution to the program.

Missions frequently do not want to pay for activities perceived to be ancillary to training that are nevertheless essential to determine training impact. For example, Bangladesh has objected to

comprehensive follow-up of trainees, and is proposing that only slightly more than ten percent of trainees receive follow-up visits.

Another issue raised is if Missions pay for an activity, the Office of Population takes a more “hands off” approach. This strategy may circumvent questions about what is most appropriate technically and strategically for primary provider IRH training programs. While activities funded by field support funds must fall within the project contract terms, activities spread across a broad range of technical and programmatic issues may create ambiguity about what PRIME does. Regardless of funding source, PRIME must provide interventions that lead to impact on RH, but the compromises that are developed may not be ideal, and may not correspond to an optimal package of RH services.

It is often difficult to integrate PRIME technical interests when the project is a participant in large, complex programs such as those in Bangladesh or India. Activities are closely linked with other bilateral components, and there is less latitude for change or innovation. In addition, USAID often enters into agreements with host countries long before PRIME or other CAs are involved, leaving less opportunity for creative training applications.

A final problem emerging with field support is that Missions want to buy services that extend past the life of the original project (as in the cases of El Salvador, India, and Ghana). This creates linkage problems: how much work will be done by PRIME, and how much prepared or held over for an alternative contractor or cooperating agency?

### **7.3.2 Conclusions**

It is essential that core funds support development and adaptation of innovative models, technical leadership, and new technologies. Experience shows that field missions will invest in innovations if they do not have to absorb the risk of failure. Seed money is important to help country institutions see what is possible. Field applications in turn contribute to refinements and adaptations of methodologies and tools, and help to ensure later acceptability.

One clear success is the experience with PAC. From the outset PRIME wanted to introduce PAC for primary providers, but initially neither had countries clamoring for service, nor examples of how to introduce PAC below the hospital level. The project developed an appropriate technical application, marketed PAC services to missions, and requested core funding from the Office of Population. PAC has now become one of the project’s most sought-after interventions.

### **7.4 USAID/W’s and Missions’ Technical and Contractual Response**

The role the CMT Division assumed in supporting the management restructuring, rather than closing down the project, is appreciated and respected. The technical guidance provided by USAID, particularly in the key results areas, is also valued.

There is a sense that USAID is moving more of the CA coordination role from itself to the CAs through contracts awarded to multiple partners, or through exhortations for collaboration and cooperation. However, financial and manpower resources are not allocated in contracts to

support the manpower and communications costs implied. The presumed efficiencies of management of mega projects have not been documented. While large contracts may be easier for USAID to administer, part of the management burden moves from USAID to the contractor, and is not adequately noted in project budgets.

This contract, like others in the Office of Population, raises important management questions that are not easily answered. What is required to create technical leadership in-house, vs. buying it from an existing institution? The equation is affected by the prestige of collaborating partners; there is frequently an advantage in paying for the expertise of an institution well-recognized by the field.

## **7.5 Recommendations**

13. Review procedures should be streamlined and greater budgetary autonomy allocated to the regional offices to enhance flexibility and responsiveness to local requests.



## 8. CONSIDERATIONS FOR A FOLLOW-ON PROJECT

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### 8.1 Should the Project Continue To Be an Integrated Family Planning/Reproductive Health/Maternal Health Project?

The evaluation team answers this question with a unanimous yes. Integrating FP with other RH services increases the number of chances for a woman to come into contact with FP services.

#### 8.1.1 Advantages of an Integrated Approach

- **Increased access:** We have learned from experience that due to women's burden of responsibilities, caring for her own needs is often placed last on the list. This is true especially when it comes to preventive health care such as family planning or prenatal care. Integrating services maximizes access to these services, meeting women's needs in a more accessible, efficient way. For example, a woman is more likely to take care of a suspected STI if the family planning provider asks her if she is having any other problems. Postpartum women who are sent home with a contraceptive method are more likely to use it than those who need to make a special trip with a new baby in tow.
- **More efficient service delivery:** Integrating FP/RH/MH into the same service delivery site is a more efficient and cost-effective way of delivering services. It often only takes a few extra minutes of a provider's time to take care of two issues instead of one once the client has already been registered, had her history taken, and an exam is under way.

#### 8.1.2 Disadvantages of an integrated approach

- **There is the potential for spreading providers too thin and thereby diffusing program strengths.** For example, a midwife whose main concern is in the immediate welfare of the mother and newborn may not stress the importance of family planning in the immediate postpartum period or provide complete counseling on all methods.
- **It is possible to overburden training programs and potentially dilute the effectiveness of training.**

PRIME's technical and programmatic strategies are right on target to maximize the impact of an integrated approach to improve access and quality to health services. The program mostly needs time to implement its programs and to fine-tune its strategies. Furthermore, more work is needed in terms of defining, selecting, and implementing which reproductive health interventions can have the best "fit" with SO 1 and make true contributions to both family planning and overall reproductive health gains.

### 8.2 Highlights of a Follow-on Project

PRIME's programmatic and technical approaches are appropriate, and should be continued in a follow-on project targeting primary providers. These include:

- pioneering work on the decentralization of PAC and its links to postabortion family planning service delivery;

- LSS and Community Partnerships for Safe Motherhood which show tremendous potential for increasing awareness and responsiveness to women's reproductive health needs, improving women's value in the community, and generating community demand for quality RH/FP services;
- increasing male involvement including couple communication, recognizing the male role in FP/RH decision-making as well as a man's own needs for FP services;
- increased focus on emergency contraception. EC covers a large unmet need and can serve as the introduction to FP services;
- increased focus on adolescent services, including removing cultural barriers and finding innovative ways to offer information and services;
- increased focus on STI/HIV prevention and treatment.

### **8.3 Enhancing Sustainability, Capacity Building, and Institutionalization**

The Population/CMT Training Results Framework is based upon what might be called the training paradigm. In this paradigm, the causes of poor performance in the workplace are identified as deficits in the skills and knowledge of individual workers to manage and perform the tasks to which they are assigned. This paradigm leads to the creation of training and education systems to deliver appropriate training. In many ways projects succeed in creating the capacity to deliver high-quality training but they have not been able to demonstrate that this training is cost-effective or leads to achievement of higher-level objectives. Training of providers may improve their skills and knowledge but does not automatically lead to improved on-the-job performance or to strategic objectives such as "increased use by women and men of voluntary practices that contribute to reduced fertility."

Most training organizations, including PRIME, now recognize that "training is not enough." They therefore search for the obstacles to effective performance and seek to remove them. These obstacles might be a poor working environment, lack of equipment and supplies, unsupportive policy environments, or inadequate supervision and management. Although efforts may be made to remove these obstacles, the core technology for performance improvement is training. When training is the core technology for change, several familiar problems are encountered that make this approach ultimately unsustainable. These problems include:

- excessive training: training needs assessments too often conclude that all providers require training. If after training they still do not perform adequately, the proposed solution is more training/refresher training;
- heavy investments in trainers, training sites, and training materials;
- opportunity costs of workers being trained;
- training overhead: trainee per diem, travel, trainer salaries, etc.

What is the solution? The paradigm must be changed from one in which training systems are the objective and training is the core technology to one in which improved provider performance is the objective and the core technologies are performance analysis, cause analysis, intervention selection, and change management.

The systems approach to improving performance is rapidly replacing training in international

business and industry and, increasingly, in health care organizations. Large corporations and hospitals are reengineering training departments or replacing them with groups that apply a new core technology. This technology is often called Human Performance Technology.

*Human Performance Technology (HPT) is a set of methods and procedures and a strategy for solving problems, related to the performance of people. It is a process of selection, analysis, design, development, implementation, and evaluation of programs to most cost-effectively influence human behavior and accomplishment. It combines three fundamental processes: Performance Analysis, Cause Analysis, and Intervention Selection and Design, and can be applied to individuals, small groups, and large corporations (International Society of Performance Improvement (ISPI)).*

PRIME, having recognized that “training is not enough,” is adapting the HPT strategy to improving provider performance in FP/RH projects. As discussed in Section 2.2 above, PRIME has carried out a five-step methodology it calls the Performance Improvement Approach (PIA) in three pilot projects. Early results of evaluation studies of these PIA projects are very promising. They demonstrate that the PIA:

- produces positive results in the improved performance of service providers;
- involves a variety of stakeholders in the identification of problems and implementation of solutions;
- can effectively utilize existing training capacity (trainers, curricula, materials);
- can identify cost-effective interventions.

If the follow-on project is oriented toward the HPT paradigm, the following capabilities will be required:

- Improved strategic planning for performance improvement. The project should conduct strategic plans that analyze provider performance, not just training needs. Strategies should include an analysis of the entire system that supports provider performance. Models for this type of strategic planning process have been developed in industry (see Svenson, Raynold A., and Rinderer, Monica J., The Training and Development Strategic Plan Handbook, 1992, Prentice-Hall)
- Implement the Performance Improvement Approach in a wider variety of projects and countries. Evaluate the costs and effectiveness of the methodology for improving performance of providers
- Develop PIA tools and training materials that can be used by project personnel with minimal outside technical expertise
- Develop more cost-effective training and non-training interventions for improving performance (see section 8.4 below)
- Increase capability to evaluate cost-effectiveness of alternative learning approaches and performance improvement interventions
- Develop capability of training organizations to market and obtain revenues for designing and conducting training for private sector providers and other health and non-health organizations
- Conduct more effective needs assessments to determine who truly needs training, how much, and when they have reached a determined level of competence. Change the concept of



training to a truly performance-based approach; that is, provide only those skills and knowledge needed to become a competent service provider

- Make better and more efficient use of the performance-based training approach by increasing the student-instructor ratio, standardizing materials and training curricula, and utilizing slides, video, and other technologies
- Conduct studies to determine the minimum amount of skill practice on models and clients required to attain competency. At present, training is often prolonged because low client flows make practice inefficient

#### **8.4 Developing Information Technology Applications**

Instruction (i.e., teaching new skills and knowledge) is only one part of human performance technology, but it is the most visible part. Fundamental to improving the performance of primary service providers is using the most appropriate learning technology. One set of technologies is classroom-based, trainer-led training of groups of service providers. While this technology has been vastly improved in PRIME's performance-based training, it is still difficult to sustain and institutionalize.

The next project should include an enhanced capacity to identify, adapt, and evaluate learning technologies that are appropriate for the service providers served by PRIME. Many of these technologies are available and used in industry, the military and other international training organizations (see Stolovich, Harold D. and Keeps, Erica J., Handbook of Human Performance Technology, 1992, Jossey-Bass for descriptions of learning methodologies and criteria for evaluating them). Although not exhaustive, a list of possible learning technology innovations that might be explored includes:

- job aids;
- self-directed learning approaches;
- tape talk (interactive low technology audio cassettes);
- radio-based training;
- indigenous, culturally appropriate learning models (songs, drama, chants, drawings);
- site visits to model sites, conferences, tours;
- use of video and still cameras to create locally produced training material;
- increasing client expectations and demand for improved performance;
- establishing web-based, easily-accessed files of training documents and materials;
- improving software and making better use of existing learning technology such as overhead projectors, charts, curriculum materials.

#### **8.5 Meeting USAID/W and Mission Needs**

- A cooperative agreement emphasizing results management and regularly reviewed performance targets would give both USAID and the implementing agency more flexibility. A cooperative agreement would reduce the monitoring burden, require fewer subcontract and procurement approvals with their attendant delays, and would be less time-dependent in completing particular activities.

- Efforts must be made to develop common performance indicators between Missions and USAID/W. Project monitoring and evaluation systems need to better fit USAID reporting needs. It is likely that there will be an ongoing need to clarify how IRs link with SOs, and how the training activities will link with and reinforce the activities of organizations with primary responsibility for other IRs.
- Mega-contracts are expensive. USAID must carefully consider what are the necessary and legitimate costs, particularly with field mechanisms in place to support fully loaded costs from the Missions. What are the advantages of shifting administrative and coordination roles to the implementing agency, and are these offset by the potential for higher cost contracts or cooperative agreements? What are the benefits of having highly reputable and well-known technical partners intimately linked under the contract mechanism, as opposed to an expanded in-house staff employed by a single organization?
- An essential RH service package has not been commonly defined and agreed upon. Components may be similar in different countries and contexts (PAC, STI/AIDS, FP, FGC, EC, breast examination, cervical cancer screening, etc.), but how are they weighted and emphasized locally? Increasingly, the field is responding to counterpart specifications, often holistic statements of RH needs. USAID and its implementing contractors must be realistic about what service providers need, and flexible in providing what a country wants.
- Because the RH definition is so inclusive, PRIME has found it difficult to turn down Mission requests for training, including some activities which stretch the technical focus of the project (i.e., child health). This risks diluting and diverting project focus and capacity, and will remain a challenge during a follow-on project.
- The lack of a coherent definition incorporating health and population priorities results in conflicting definitions of what is meant by Performance Improvement in trainee skills. For the Office of Population, it means FP; whereas in the field, definitions are more broad, often incorporating lifesaving skills, safe motherhood, and other interventions.

## 8.6 Results Framework for the Follow-on Project

The Office of Population/CMT Division is drafting a new Strategic Objective (SO): *“Improved provider performance and sustainable, national systems for training and education in family planning and reproductive health.”* Four Intermediate Results (IRs) have been identified to achieve this SO:

- IR 1: Strengthened pre-service education, in-service training, and continuing education systems
- IR 2: Improved management systems
- IR 3: Improved policy environment
- IR 4: Better informed and empowered clients and communities

The follow-on project to PRIME will focus its efforts on IR 1 and its sub-results. Continued work on the PIA will contribute to IRs 2, 3, and 4. Monitoring, research and evaluation activities

will contribute to IR 1, improving the application of information technology for training and the development and practical application of more effective and appropriate approaches for training and performance improvement of frontline and non-traditional providers.

Work to build capacity of national institutions in training programs and development and dissemination of national guidelines and supervisory, monitoring and evaluation systems will contribute to IR 2 and IR 3. Continuation and refinements of interventions such as training TBAs and ISM practitioners and work on community partnerships for safe motherhood (CPSM) and increased focus on adolescents and male involvement in reproductive health will contribute to achievement of IR 4 results.

The follow-on to the PRIME project should focus on developing indicators for all seven sub-results under IR 1 and possibly one or two additional IR 1 sub-results (SRs) (such as SR 1.8, “Improved and simplified monitoring instruments and supervisory checklist developed and used to improve provider performance”). Illustrative examples of training-related indicators that can measure project contributions toward achieving the CMT’s training SO, IRs, and SRs may include the following:

#### **8.6.1 SO Indicators**

- Percent of trained service providers (from pre-service and/or in-service training programs) performing to standard.
- Number of countries with strengthened training capacity that produce an increased number of competent service providers for a range of reproductive health services.

#### **8.6.2 IR 1 Indicators**

- Number of in-service reproductive health training programs established/strengthened and functioning for one or more types of community-based service providers (i.e., CBD workers, health assistants, midwives, TBAs, indigenous systems medicine practitioners).
- Number of pre-service reproductive health training programs established or strengthened and functioning in one or more training areas (i.e., nursing, midwifery, medicine, health worker).

#### **8.6.3 IR 2 Indicators**

- Numbers of trainees in specific reproductive health services deployed to an appropriate service delivery site and job assignment following training (i.e., at sites which have the logistics, supply, IEC, and clientele demand for such services).
- Numbers of supervisory visits conducted during a specified period; percent of visits in which checklists were used and constructive feedback was provided.
- A training monitoring and evaluation system has been established at the national, regional, or institutional level that documents the number of RH professionals trained in each RH area,

by type of training and type of provider trained, percent of trained providers using their training knowledge and skills, and percent of trainees followed-up and performing RH services to standard.

#### **8.6.4 IR 3 Indicators**

- Number of countries in which the process of revising, updating, disseminating, and implementing national service delivery guidelines for reproductive health services is institutionalized.
- A network of RH experts and master trainers is established, recognized, and utilized nationally and internationally for providing RH technical assistance and training.

#### **8.6.5 IR 4 Indicators**

- Number of client-focused community-based training initiatives in reproductive health introduced in selected countries which contribute to increased client RH knowledge and health-seeking behavior and improved community support for reproductive health behavior.

The follow-on to PRIME will need to collaborate more with other CAs working in the area of management improvement, policy environment, and IEC to inform and empower clients and communities. This effort will contribute to the achievement of other CMT sub-results, but the follow-on PRIME project will be held accountable only for their specific sub-results, many of which will fall under IR 1. Indicators for specific sub-results will also need to be developed.

### **8.7 Suggested Actions to Achieve Intermediate Results**

#### **IR 1**

- Expand training and learning options, placing greater emphasis on innovative learning approaches.
- Prepare a guide for developing training and materials (job aids) for low-literacy audiences. Become a global, technical leader in this field by collecting and updating what is known with new research and fieldwork.
- Document participatory, hands-on, and performance-based training strategies.
- Increase collaboration with JHPIEGO and other training partners to create a seamless training strategy that recognizes the role of primary providers and fosters cooperation and support.
- Increase collaboration with other CAs and technical partners to effectively address training system shortcomings.
- Develop better links between primary and tertiary care (protocols for care must be the same at all levels; strengthen and coordinate system referrals).
- Expand training options (a variety of cost-effective, time-efficient models, including distance learning).
- Develop stronger advocacy for non-traditional training, substantiating skills retention and cost of different training types as a choice factor (i.e., present alternative cost scenarios

during negotiations and intervention design); be more proactive with different training methods. Demonstrate their utility and promote new technologies to USAID's and host country partners.

- Develop tools to strengthen USAID Mission awareness of training alternatives.
- Build capacity for advanced training skills and programming through fellowships, long-term training, or high-level on-the-job training.
- Continue to move from improving knowledge or skills to performance-based training; develop client-focused performance standards (whether client needs met, rather than provider skills).
- Put more emphasis on supervision, team training, coaches, partner support, on-the-job training, etc.
- Capitalize on local resources to enhance South-South collaboration, information sharing, and skills transfer.
- Systematically assess training effects to identify the determinants of fertility preferences and contraceptive use.

## **IR 2**

- Institutions need support and interventions to develop long-range strategic plans with objectives and landmarks to ensure commitment and resource allocation. Comprehensive negotiations may be required to select suitable training approaches and to stipulate the obligations of host agencies.
- Put greater emphasis on detailed program planning, particularly in countries with multiple activities; strengthen capacity for data interpretation and use in decision-making and resource allocation.
- Improve human resource recruitment, deployment, and development strategies and systems.

## **IR 3**

- Build enabling environments for primary providers (joint programming among CAs and host country institutions; IEC campaigns; community mobilization, etc.).
- Continue development of national RH policies, standards, guidelines, and protocols, as appropriate.

## **IR 4**

- Strengthen provider-community links (identify and eliminate social barriers to services, develop community early warning systems, transport networks, etc.).
- Prepare targeted publication and dissemination strategies, including audience identification, product (publication) line, frequency of publication, person(s) responsible, and format. Use different fora for dissemination: expanded web site; increased conference participation; professional associations in host countries; and faster production of user-friendly materials.
- A future emphasis on diverse primary providers has implications for material development—more reliance on pictorial references and job aids, materials prepared in local languages and dialects.
- Limits should be placed on development of checklists, forms, etc. Serious effort should be

made to identify the most useful tools and job aides and make them as user-friendly as possible (laminated sheets, pocket books of indicators, etc.).

- Develop partnerships with community development organizations and agencies to foster local awareness and demand for quality services.
- Make greater use of mass media, particularly radio, to generate community awareness and demand for quality services.

## **REVISED TRAINING RESULTS PACKAGE SUB-RESULTS**

### **Intermediate Result 1: Strengthened Pre-Service Education, In-Service Training, and Continuing Education Systems**

- SR 1.1 Trained faculty and master trainers teaching/practicing in professional schools and training institutions
- SR 1.2 Capacity for FP/RH curriculum development established, mandatory courses in FP/RH instituted, and appropriate materials and technologies utilized to implement and evaluate curricula and courses
- SR 1.3 Clinical training sites and centers established and fully functioning at optimal performance
- SR 1.4 Demonstrated adherence to quality standards by professional schools, clinical training, and formal and non-formal education sites
- SR 1.5 Links in place for provider mentoring between professional schools and associations and service delivery sites
- SR 1.6 Improved application of information technology for training
- SR 1.7 Effective and appropriate approaches for training frontline and non-traditional providers developed, tested, and used

### **Intermediate Result 2: Improved Management Support Systems**

- SR 2.1 Appropriate logistical support available for provider performance at all levels
- SR 2.2 Personnel policies, procedures, and supervision systems in place
- SR 2.3 Financial management systems functioning
- SR 2.4 Capacity for strategic planning for performance improvement of trained personnel established
- SR 2.5 Monitoring and information systems and tools in place and used to determine training needs and resources
- SR 2.6 Approaches to monitoring and evaluating the effect of training on provider performance and quality of service delivery tested and used
- SR 2.7 Approaches for cost containment and recovery tested and used

### **Intermediate Result 3: Improved Policy Environment**

- SR 3.1 Budget and resources for training allocated at the national, regional, and institutional levels
- SR 3.2 Improved national standards, guidelines, norms, and protocols for service delivery and education sites
- SR 3.3 Improved policy development, dissemination, and implementation process
- SR 3.4 Leadership training, support, and mentoring programs in place

### **Intermediate Result 4: Better Informed and Empowered Clients and Communities**

- SR 4.1 Women and men better informed about quality services
- SR 4.2 Improved partner communication
- SR 4.3 Changed community norms to facilitate improved reproductive health behavior
- SR 4.4 Strengthened provider-community links developed

## **8.8 Recommendations for Monitoring, Evaluation, and Research**

- Reduce the number of indicators and make them consistent with the Strategic Objectives, Intermediate Results, and Sub-Results of USAID (This will contribute to IR 1 (SR 1.7) and IR 2 (SR 2.5)).
- Reduce the number and length of the checklists used for monitoring and evaluation. Consider having a small number of laminated checklists covering multiple topics rather having many separate checklists bound in heavy manuals that are not practical for use in the field (This will contribute to IR 2 (SR 2.5)).
- Improve the proportion of trainees followed-up with supportive monitoring and supervision (This will contribute to IR 2 (SR 2.2 and 2.5)).
- Select three or four countries for in-depth research and training evaluations (e.g., Operations Research (OR) and impact studies). This will require closer collaboration with other CAs and appropriate, complementary projects. Conduct more research on the PIA, CPI, PAC, and integrated RH initiatives using both qualitative and quantitative methods (This will contribute to IR 1 (SR 1.6 and 1.7 and IR 2 (SR 2.5)).
- Conduct training-related Operations Research (e.g., testing alternative training strategies and different ILAs (distance learning approaches versus participatory approach versus more formal didactic instruction approach); performance-based evaluation models; or different training formats using experimental or quasi-experimental designs) (This will contribute to IR 1 (SR 1.5 and 1.7 and IR 2 (SR 2.5)).
- Conduct impact evaluations in one country in each region using DHS survey panel data and service facility data that have been collected over at least two points in time (This will contribute to IR 1 (SR 1.6 and 1.7) and IR 2 (SR 2.5)).
- Use the systems approach in evaluations so that factors other than training affecting outcomes are properly accounted for in interventions and their evaluations (e.g., IEC and logistics and supplies)(This will contribute to all IRs).
- Ensure that the messages and lessons learned from research and evaluation results are clearly articulated and more widely disseminated in concise, well-edited reports and published articles and ensure that the evaluation results are actually used at the local as well as national level for decision-making to improve program performance. For example, one-page attractive research and evaluation update reports should be prepared periodically and disseminated (This will contribute to IR 2 (SR 2.5) and IR 3 (SR 3.3)).
- Conduct cost-effectiveness studies of alternative training approaches to help ensure better sustainability of training programs. Research should be conducted on: the relative cost-effectiveness of the tape-talk training approach; the provider-targeted radio drama approach and computerized distance learning approach; integrated versus non-integrated RH training; PIA versus the status quo (control group); the cost-effectiveness of alternative training formats in terms of size of classes and duration of training sessions (This will contribute to



## **APPENDICES**

# **APPENDIX A**

## **EVALUATION SCOPE OF WORK**

### **PRIME PROJECT**

#### **I. BASIC INFORMATION**

**Project Name: The Primary Providers' Training and Education in Reproductive Health Project (PRIME)**

**Contract Number: CCP-3072-C-00-5005-00**

**Central Funding Agreement Value: \$50,452,303**

**Obligation to Date: \$45,111,800**

#### **II. BACKGROUND**

##### **A. Overview**

The PRIME project is a follow-on to the Paramedical, Auxiliary, and Community Personnel (PAC I and PAC II) Projects which USAID has supported since 1979. PRIME is the leading Office of Population project providing training to essential primary health personnel who reach clients at the most basic level of service delivery.

In 1994, The International Conference on Population and Development endorsed a broad strategy for slowing population growth rates and improving women's health. In response to the ICPD and the Office of Population's 1995 strategic plan, the PRIME project was designed as an integrated reproductive health project. The PRIME contract expanded upon the purpose of its predecessor projects by broadening the technical scope of the project to integrate selected reproductive health care interventions into family planning training programs in order to respond to client's reproductive health needs. Under appropriate circumstances, the PRIME project was expected to incorporate STI prevention and control, safe motherhood, breastfeeding and FGM into family planning training in order to enable primary providers to reach new client groups and increase the quality and utilization of family planning services.

An emphasis of the PRIME project is to develop the capacity of host countries to train their own personnel and strengthen their national training system: both pre-service and in-service. PRIME's mandate was also broadened from training to human resources development to include the management and deployment of trained personnel as well as the actual training of providers. Previous projects emphasized the training of personnel and neglected to examine the enabling environment. This project was positioned to examine and develop interventions to create a

supportive environment for service providers to maximize the training inputs. Interventions identified in the contract included: strategic planning, management and supervision; deployment of personnel; policy and quality issues; gender barriers; etc.

Other areas of emphasis in the project design are the collection of impact data and the linkage between training and improved quality of service delivery. The project was expected to measure the impact of training on service delivery and to develop indicators to measure the sustainability of training activities.

Overall, the goal of the PRIME project is to improve the reproductive health of women and men in developing countries by increasing access to and quality of family planning and reproductive health care services. The focus of the project is to provide technical assistance to institutionalize training and to ultimately move countries to achieve a sustainable training system.

## **B. USAID's Population, Health and Nutrition Center**

The Population, Health and Nutrition Center at USAID has five strategic objectives that support the Agency goal to stabilize world population and protect human health. The Center's five strategic objectives represent an integrated approach to reproductive health. SO 1 covers family planning, SO 2 maternal health and nutrition, SO 3 child health and nutrition, SO 4 STIs and HIV/AIDS and SO 5 infectious diseases. These objectives are:

- SO 1: Increased use by men and women of voluntary practices that contribute to reduced fertility;
- SO 2: Increased use of key maternal health and nutrition interventions;
- SO 3: Increased use of key child health and nutrition interventions;
- SO 4: Increased use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic; and
- SO 5: Increased use of proven interventions to reduce the threat of infectious diseases of major public health importance.

The PRIME project was designed and is managed by the Communication, Management and Training (CMT) Division of the Office of Population. The CMT division primarily contributes to SO 1, but because of the broadened technical focus of the contract, PRIME also contributes to SO 2. This evaluation should particularly address the contributions to SO 1 and SO 2.

SO 1 has four intermediate results, which are lower level results that help to guide programs and activities and allow the Center to monitor progress. The four intermediate results for SO 1 are:

- IR 1.1: New and improved technologies and approaches for family planning programs;
- IR 1.2: Improved policy environment and increased global resources for family planning programs;
- IR 1.3: Enhanced capacity for public, private, NGO and community-based organizations to design, implement, evaluate, and finance sustainable family planning

programs;

IR 1.4: Increased access to, quality of, cost-effectiveness of and motivation for use of family planning, breastfeeding and selected reproductive health information and services.

The four intermediate results of the SO which focuses on maternal health are described below:

IR 2.1: Effective and appropriate maternal health and nutrition interventions and approaches identified, developed, evaluated and/or disseminated;

IR 2.2: Improved policy environment for maternal health and nutrition programs;

IR 2.3: Improved capabilities of individuals, families, and communities to protect and enhance maternal health and nutrition;

IR 2.4: Increased access to, and availability of, quality maternal health and nutrition programs and services.

### **C. CMT Division: Training Portfolio**

The training portfolio in the CMT Division works to build the capacity of host countries to train and support their own personnel: doctors, nurses, midwives, community health aides, traditional birth attendants, etc. The projects in the CMT division also significantly contribute to capacity building, (intermediate result 1.3) increased access to quality of, cost-effectiveness of and motivation for use of family planning programs (intermediate result 1.4) and ultimately to a sustainable family planning/reproductive health program.

There are two large training projects in the CMT Division: PRIME and JHPIEGO (The Johns Hopkins Program for International Education in Reproductive Health). PRIME focuses on front-line providers who reach clients with family planning and reproductive health care services at the primary or community level. The target personnel to reach are: nurses, midwives, community health workers, community health attendants, primary care physicians, pharmacists, traditional birth attendants, and other community based health workers. JHPIEGO focuses on training higher level cadres of personnel: physicians, obstetricians and gynecologists, pre-service professors and tutors, nurses, and midwives, primarily at university hospitals, tertiary care hospitals, district hospitals, and provincial or regional MCH/FP clinics. Both PRIME and JHPIEGO work in pre-service and in-service settings, but JHPIEGO has historically played a larger role in the pre-service arena.

PRIME and JHPIEGO represent the flagship training projects for the Office of Population. Other divisions have projects that conduct training including: AVSC, SEATS, Pathfinder, CEDPA, CARE, etc. These projects are also focused on improving access to and quality of FP/RH services, however, they are not focused on the development of sustainable training systems.

### **D. New Training Results Package**

A multi-disciplinary team from the Population, Health and Nutrition Center (PHNC) at USAID

has developed a draft results framework and concept paper for future training projects and procurements in the CMT division. The **strategic objective for the results package is: Improved provider performance and national capacity for training and education for family planning and other reproductive health interventions.** The intermediate results identified to achieve the strategic objective include:

- IR 1: Strengthened Pre-Service Education, In-Service Training, and Continuing Education Systems
- IR 2: Improved Management and Support Systems for Training
- IR 3: Improved Policy Environment for Training
- IR 4: Better Informed and Empowered Clients

The follow-on project will be linked to this results framework and report on the strategic objective and several intermediate results. The evaluation team should use this results framework and concept paper to provide guidance and direction to the CMT division for the follow on PRIME project that will be developed in early 1999.

### **III. PURPOSE OF THE EVALUATION**

This evaluation will provide important information for the development of a follow-on program. PRIME is one of the first integrated family planning/reproductive health projects and the evaluation team should spend fifty percent of their time assessing the accomplishments and impact of this integrated program design. Fifty percent of the evaluation should focus on the future needs of USAID/W, USAID Missions, and host country partners, taking into account new and emerging issues relevant to training and improving on the job performance. The future directions provided should be linked to the Training Results Package and concept paper developed by the PHNC.

The objectives of this evaluation are:

1. To identify the major technical and programmatic strengths and weaknesses of the project.
2. To assess the effectiveness of PRIME's approach to building national capacity of developing countries to train their own personnel and foster sustainable development.
3. To provide recommendations for the design and implementation of the follow-on project.

### **IV. STATEMENT OF WORK:**

Within the above stated objectives, the following describes specific questions or issues to be addressed under this evaluation. *(Please note - the questions/issues that are highlighted in italics will be answered by the PRIME project prior to the start of the evaluation; the evaluation team should use these answers to build upon the subsequent questions within each section.)*

**1. To what extent has the project accomplished the purposes of the project design?**

**A. Major Results and Accomplishments of the Project:**

1. Given the broadened mandate outlined in the PRIME contract, what are the 5 major results of the project? *What technical leadership issues and new initiatives has the project documented results in over the past four years?* What has been the impact of those results? In what technical areas did PRIME have limited or no significant accomplishments and results? Please describe briefly why the project had limited or no success in those areas.

**B. Sustainability and Capacity Building:**

1. How effective has PRIME been in developing the capacity of host countries to train their own health personnel? More specifically, please examine and analyze the strengths and weaknesses of PRIME's work in the following areas to date:
  - a. *What are PRIME's definitions and strategies for the following: sustainability, capacity building, and institutionalization. How does PRIME track progress and measure results?* In what countries or with which institutions has PRIME demonstrated progress in these areas?
  - b. What are the strengths and limitations of PRIME's country strategic training plans to describe the needs of a national training system (both in-service and pre-service) and track progress to date?
  - c. *How does PRIME work with in-country institutions to develop a clear understanding of its expectations for program continuation once PRIME's TA is finished. Is there a common vision and mutual accountability for expected outputs and results?*
  - d. How well has PRIME collaborated with other CAs to carry out joint needs assessments and work together to design a cohesive approach towards sustainability?

**C. Contract Deliverables:**

1. How well has the project done in completing the contract deliverables as set forth in the contract. Please review the deliverables, and note the project strengths and constraints.

**D. Maximizing Access and Quality (MAQ)/Global Technical Leadership**

1. *What are PRIME's strategy and programmatic approaches to maximize access and quality of*

*family planning and reproductive health services?*

2. *What has been PRIME's experience in the development of national FP/RH/MH guidelines?*

Has PRIME documented the impact that guidelines have on access and quality of FP/RH services? Please describe PRIME's strengths and weaknesses in the use of guidelines: development, dissemination, use at service delivery sites, use in pre-service and in-service training, etc.

3. *How does PRIME define quality of care?* How has PRIME linked quality of care to training and performance of providers? What has been the impact of PRIME's work in quality of care? What are the best practices and lessons learned to institutionalize quality of care for frontline providers.

4. Please comment on PRIME's technical, clinical, and programmatic contributions in the following areas: family planning, postabortion care, STI prevention, and maternal health. What have been the significant accomplishments and lessons learned in these technical areas? What technical and/or programmatic interventions could be strengthened?

#### E. Training and Performance Improvement Approaches

1. What have been the significant results of PRIME's work in applying new or improving existing training interventions such as distance learning, on-the-job-training, self-directed learning and interactive technology? Does PRIME have adequate staff to develop and test approaches in this area? What are the best practices that PRIME has documented in this area? How successfully have these approaches been used in developing countries?

2. PRIME has played an instrumental role in developing a performance improvement approach that offers new opportunities for organizations to identify the causes of performance problems and targets both training and non-training interventions. What are the results of PRIME's work in this area? What are the advantages and disadvantages of this approach? What is the potential of global application? Has PRIME demonstrated that this approach can improve the performance of primary providers?

#### F. Publications and Technical Materials

1. What are the most useful and relevant publications developed by the project? Are they being used by in country institutions? other CAs? other donors? What documents have not been beneficial? Why? How can PRIME improve in the development, design, testing, and dissemination of publications. Please provide examples.

2. *Given the other CAs working in training, how does PRIME ensure that it does not duplicate the work of others?* To what extent have other CAs found PRIME's materials

useful and relevant. Please provide examples.

G. Monitoring and Evaluation

1. *What monitoring and evaluation system does PRIME use in its headquarters and regional offices to track progress toward accomplishing contract deliverables and annual workplan objectives? How can PRIME strengthen its global system for tracking and measuring progress and achievements of results? How does PRIME monitor the changes in performance of training participants?*
2. What have been the most significant project results in the research and evaluation division? Is there sufficient and adequate staff to carry out the functions of research and evaluation division? What are the relationships between the field and headquarters in this area? How can it be strengthened?
3. *What actions has the PRIME project taken to date to disseminate research and evaluation results? What steps should be taken in the last year of the project to maximize dissemination and use of results, instruments, tools, and lessons learned?*

**2. How effective is the organizational and management structure at PRIME?**

The organizational structure was changed in the third year of the project to be more responsive to USAID/W and the field, especially in the Latin American and Caribbean Region.

1. Has the new structure and personnel been able to respond effectively to the technical, programmatic, management, and communication needs of a global project? Have the technical partners been able to work effectively to provide technical and programmatic resources?
2. *How do the field offices relate to headquarters? What are the strengths and constraints of the decentralized approach to programming and technical assistance? How can the field and headquarters work more effectively together to implement a worldwide project using core and field support funds?*

**3. USAID Management**

- A. How well has USAID managed the project? Please comment on the relationship with: The Senior Technical Advisor; The Office of Population staff and leadership; the PHN Center; the Office of Procurement; and the USAID/Missions.
- B. Has USAID/Washington and USAID/Missions been appropriately responsive technically and contractually?

**4. Future Directions for USAID Frontline Provider's Training**



- A. What should be the technical and programmatic priorities under the new project?
1. Should the project continue to be an integrated FP/RH/MH project? What are the advantages and disadvantages of this approach? How do we maximize the impact of the future project?
  2. What are the new and continuing technical and programmatic areas in FP/RH that should be highlighted in the follow-on project?
  3. What are the critical performance interventions and approaches that should be addressed—management? supervision? deployment issues? motivation/incentives? others?

Using the Training Results Framework, for each intermediate result, please provide recommendations for programmatic and technical areas where you think the follow-on project can have most impact. (This is a high priority area and the Senior Technical Advisor will use this information to develop activities needed to be carried out under each intermediate result and sub-result.)

How should the next project be designed to focus and enhance sustainability, capacity building, and institutionalization?

What should the follow-on project's role be in developing information technology applications (low or high end) and distance learning models for frontline providers?

- E. How can the project best meet USAID/Mission needs (e.g., having a framework, yet enough flexibility for country-level programming)?

## **V. MATERIALS AND PROCEDURES**

### **A. Data Sources**

The evaluation team will review all project documentation including but not limited to the following: PRIME's contract, annual workplans, trip reports, project documents and publications, management reviews, etc.

### **B. Methods of Data Collection**

**Data gathered by interviews, e-mails, and group discussions.**

The evaluation team will interview PRIME staff, consultants and organizations working with PRIME including USAID/W staff, Mission personnel, CAs stateside and in the field, and NGOs and PVOs.

Within USAID/W, the evaluation team will meet with G/PHN/POP and G/PHN/HN staff including the Front Office, CMT Division, Research Division, Family Planning Services

Division, Policy and Evaluation Division, and Nutrition and Maternal Health Division. In addition the team should meet with staff in the Office of Field and Program Support and country coordinators who manage key countries where PRIME is providing technical assistance.

The CMT Division will send a cable or e-mail to the appropriate field missions for input and feedback on PRIME's strengths and weaknesses. The Missions will be asked to provide information about training activities undertaken by PRIME and about the future role and needs to better design PRIME II. Based upon review of Mission responses, the team may follow-up on these responses with interviews by telephone or e-mail to Mission staff in select countries.

### **Field Visits**

After reviewing documents, meeting USAID staff and PRIME headquarters staff, the evaluation team will visit India (pending status of economic sanctions), and one African country, Tanzania or Ghana. In addition, the team will review documentation on key countries not visited. This review should provide information and lessons learned on the impact of PRIME's efforts in developing an effective integrated reproductive health model and contribution made to capacity building and institutionalization of technical assistance.

### **C. Duration and Timing of the Evaluation**

The evaluation will begin in mid-late January, 1999. A total of six weeks is estimated for data collection and drafting the report. Once the team leader receives comments on the first draft (Week 8), s(he) will require additional time to incorporate them into the report. The full time line is described below:

Week 1:	Team Planning Meeting 2 days in Washington (POPTECH) and 1 day at AID/W with CMT Division, other CTOs, and the Front Office
Week 2:	4 days in Chapel Hill meeting with PRIME staff, PRIME partners and interviewing CAs
Week 3-4:	Field Visits: One week in India and Ghana
Week 5:	Washington DC; executive summary available for CTO; debrief AID/W and PRIME headquarters on major findings and issues
Week 6:	First draft received at POPTECH and copies distributed to team members, USAID Senior Technical Advisor, CA, and assessment manager for comments.
Week 8:	Comments received by POPTECH and sent to team leader.
Week 10:	Team leader turns in 2nd draft with comments incorporated.
Week 13:	POPTECH editing staff edits/formats report and sends clearance draft to USAID Senior Technical Advisor for approval.
Week 15:	USAID gives final clearance/approval of report.
Week 16/17	POPTECH makes final changes and report sent out for printing and distribution.

### **E. Team Composition**

The evaluation team will consist of four members:

A Chief of Party who knows PHNC programs and has 10 years experience in design, implementation, and evaluation of FP/RH global programs. The person should have both field experience and have an excellent knowledge of the PHNC strategic objectives, especially SO 1 (family planning) and SO 2 (maternal health).

A clinical specialist, preferably a clinical nurse midwife who has clinical expertise in family planning, reproductive health, and maternal health care.

A training/performance specialist who has experience working in developing countries and has demonstrated expertise in adult learning, competency-based training, and performance improvement.

An evaluation and research specialist that has worked on developing monitoring and evaluation systems and has a good understanding of research.

## **VI. FUNDING AND LOGISTICAL SUPPORT**

All funding and logistical support for the PRIME evaluation will be provide through the Population Technical Assistance Project (POPTECH). Activities that will be covered include: recruitment of the evaluation team; payment of evaluation team members for six-day work weeks; support for all expenses related to the evaluation; logistical support and publication of the draft and final report.

## APPENDIX B

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<sup>2</sup> A list of additional PRIME materials provided to the evaluation team is included in Appendix G.

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## **APPENDIX C**

### **Contact List**

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## APPENDIX D

### PRIME Contract Deliverables

Objective/Deliverable	Achievements by end of 1998	1999 projections	Total (vs. contract)
1. Strategic training plans in private and public sectors	<b>18 countries:</b> Bangladesh, Benin, Burkina Faso, El Salvador, Ghana, Guinea, India, Indonesia, Mali, Mexico, Morocco, Oman, Peru, South Africa, Tanzania, Togo, Uganda, Yemen (in 16 public sector and 11 private sector institutions)	<b>1 country</b>  <b>Kenya</b>	<b>19</b>
2 a) At least 1 pre-service institution per cadre per country with FP/RH added to core curricula*	<b>Curricula for 8 cadres in 5 countries:</b> Indonesia, Morocco, Paraguay (2), Tanzania (2), Yemen (2).	ECSACON (14 countries, including: South Africa, Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe)	<b>8 cadres in 5 countries</b> as well as in 14 ECSACON countries (15 target countries in contract)
2 b) FP/RH added to in-service curricula	<b>Curricula for 32 cadres in 15 countries:</b> Bangladesh, Benin (2), Burkina Faso (2), El Salvador (2), Ghana (3), Guinea, India (5), Indonesia, Kenya, Mexico, Peru (2), South Africa, Tanzania (5), Togo (2), Uganda (3).	<b>Morocco</b>	<b>33 cadres in 16 countries (not in contract)</b>
3. At least 5 faculty per pre-service institution trained in implementing revised curriculum (1st generation)	<b>209</b> (in Indonesia, Lesotho, Morocco, Paraguay, Tanzania, Uganda, Yemen and Zambia)	<b>28 (in Indonesia) in 99</b>	<b>237 (5 in contract)</b>
4. Training divisions in public and private sector institutions assisted in developing planning, management, and evaluation capability for HR programs and activities	<b>31 training divisions in 14 countries:</b> Bangladesh, Benin, El Salvador, Ghana, Guinea, India, Indonesia, Mali, Mexico, Morocco, South Africa, Tanzania, Uganda and Yemen		<b>31 divisions in 14 countries</b> (2 public and private institutions per country in contract)
5. Establishment of FP policy guidelines supporting extended access by using community providers and decreasing medical barriers	<b>6 countries + ESCACON:</b> El Salvador, Ghana, Indonesia, Kenya, Mali, and Paraguay	<b>Tanzania and Uganda</b>	<b>8 countries</b> plus 12 ESCACON (10 target countries in contract)

\*Objective 2a and 3 are linked except in the cases of Zambia, Uganda and Lesotho, where curriculum development did not lead to training of faculty

Objective/Deliverable	Achievements by end of 1998	1999 projections	Total (vs. contract)
6. Operations research efforts or special studies	<b>Completed (9 with final reports):</b>  Tanzania Health Attendants (Phase I), Tanzania Provider Follow-up, Gujarat Follow-up, Burkina Faso DAPP, Ghana CBD Sector Assessment, Nicaragua CBD Characteristics, Ghana CBD Supervisor Impact Study, Jhansi Sub-center Assessment, ISM Follow-up	<b>Expect completion in 1999 (14)</b>  Uganda Adolescent Study, Uganda PAC, Kenya PAC, Ghana LSS/PAC/FP, FP Discontinuation/ CPI, RH Integration into FP, Morocco DBL, Performance Improvement Pilot Studies (Burkina Faso, DR), India - Community Partnerships, Benin DAPP, South Africa DBL Case  Study, Tanzania Health Attendant Study (Phase 2), Tanzania IUD Study.	<b>23 studies</b>  (10 studies in contract)
7. New FP/RH trainers trained	<b>1283</b>	<b>400</b> more anticipated	<b>1600</b> (500 in contract)
8. 1st, 2nd, 3rd generation providers trained (estimate)**	<b>250,000</b> (estimated)	<b>80,000</b> (estimated)	<b>330,000</b> (100,000 in contract)
9. Increase in new users	<b>Illustrative impact studies:</b> 1) Tanzania 1996 - in 1st 6 months after training, at sites with their first newly trained providers 135% increase in number of users, at sites where newly trained provider joined a previously trained provider - 37% increase.  2) In Unnao and Allahabad, India - volume more than doubled in 3 months post training (ISM).	Tanzania Health Attendant Study, Phase 2 will provide additional impact data.	
10. Increase in FP service delivery points	<b>945</b> 800 documented new sites in India (ISM), 145 new sites in Ghana (GRMA).	<b>600</b> (projecting expansion at a rate similar to the first 4 years)	<b>1500</b>
11. Supervisors & administrators trained in monitoring & follow-up, and have annual supervision plan	<b>379</b>	<b>75</b>	<b>450</b> (15 supervisors in contract)
12. Study factors contributing to contraceptive discontinuation	Study plan prepared	Study under way in Togo	<b>1</b> (1 in contract)

\*\* estimate calculated from number of first generation trainers trained, using formula from PRIME Evaluation and Research Plan, Vol 1, p 34

## **APPENDIX E**

### **PRIME Project Monitoring and Evaluation Systems**

#### **1. MONITORING**

PRIME has established a monitoring system to track progress made toward accomplishing contract objectives/deliverables and annual workplans. The monitoring data are collected from a variety of data sources and reports from the field. The monitoring information is collated in the PRIME regional offices and then sent to the PRIME headquarters office in Chapel Hill. Information from the monitoring system is then reported to USAID/W, USAID Missions, and host country institutions on a regular basis.

The regional offices report progress on more than a dozen project objectives/deliverables to PRIME headquarters through a regional quarterly report. Information collected for the regional quarterly reports includes number of training divisions receiving technical or material assistance; number of pre-service institutions assisted; development of policy and procedure guidelines; development of strategic training plans; and other variables.

PRIME headquarters office tracks PRIME interventions in each project country through a training database, which maintains up-to-date information on the total number and type of family planning and reproductive health service providers (e.g., nurse-midwives, TBAs, health assistants, physicians, traditional medicine practitioners, and pharmacists), trainers, pre-service tutors, preceptors, and supervisors trained under the PRIME project. The training database also tracks some “non-training” activities that require technical assistance and travel to project sites by PRIME headquarters staff and consultants.

Monitoring of progress of various aspects of PRIME projects is also accomplished through the use of monthly regional reports, trip reports, monthly activity reports to USAID, the annual portfolio review, and quarterly performance reports. PRIME projects have periodic project reviews reporting on project progress and accomplishments, including mid-term reports and end-of-project reports.

PRIME has recently developed a computerized prototype for a new Rapid Results Reporting System (RRRS). The RRRS will ultimately be integrated with the other monitoring components described above into a comprehensive computerized effort to report on key project indicators and results to improve planning and monitor progress in achieving the strategic objectives, intermediate results, and sub-results. Although the RRRS is not yet fully operational, PRIME expects that the RRRS will ultimately facilitate reporting and make project data more easily accessible and usable.

Special yearly reports are also prepared for USAID/W, PRIME program officers and PRIME partners and incorporate information from the regional quarterly reports, the training database, and technical reports on service access and quality. Some of these special yearly reports have been: PRIME Achievements and Impacts: 1996-1997; PRIME at Mid-Point; PRIME in Year 4;

and the annual workplans. The special yearly reports summarize accomplishments in the development of strategic training systems, improvements in RH/FP services access and use, and service policy development and use.

## **2. EVALUATION**

PRIME's research and evaluation activities began with the development of the three volumes of the PRIME Evaluation and Research Plan, which include various methods, guidelines, formats protocols, and instruments, including needs assessment checklists, research proposals and report formats, questionnaires, numerous skills assessment tools and observation checklists, focus group discussion topic guidelines, training follow-up instruments, and participant reaction forms. These instruments were used for conducting training evaluations at what Kirkpatrick (1994) classifies as Level 1 (trainees reaction to training) and Level 2 (evaluation of changes in trainees knowledge and skills). Additional PRIME project evaluation activities were at Level 3 (evaluation of actual on-the-job performance), notably the Indonesia Performance Evaluation; Health Attendants Impact; Ghana PPAG Supervisors Impact; Togo follow-up for Village Health Volunteers; Ghana Performance Assessment of LSS/PAC; and the Morocco DBL Evaluation. Few evaluations were at Level 4 (assessments of the effects of trainees' improved performances on actual service outcomes and health impact, but an operations research study is planned in El Salvador in 1999 to assess the effectiveness of trained MOH health promoters and TBAs).

A total of 39 PRIME evaluation studies have been completed to date, ranging from simple needs assessments and follow-up study designs to more complex operations research intervention studies and impact evaluations. Another 29 evaluations and special studies are ongoing and many of these are projected to be completed by the end of 1999. Delays in the implementation of some training interventions have made final evaluations not feasible during the current project period.

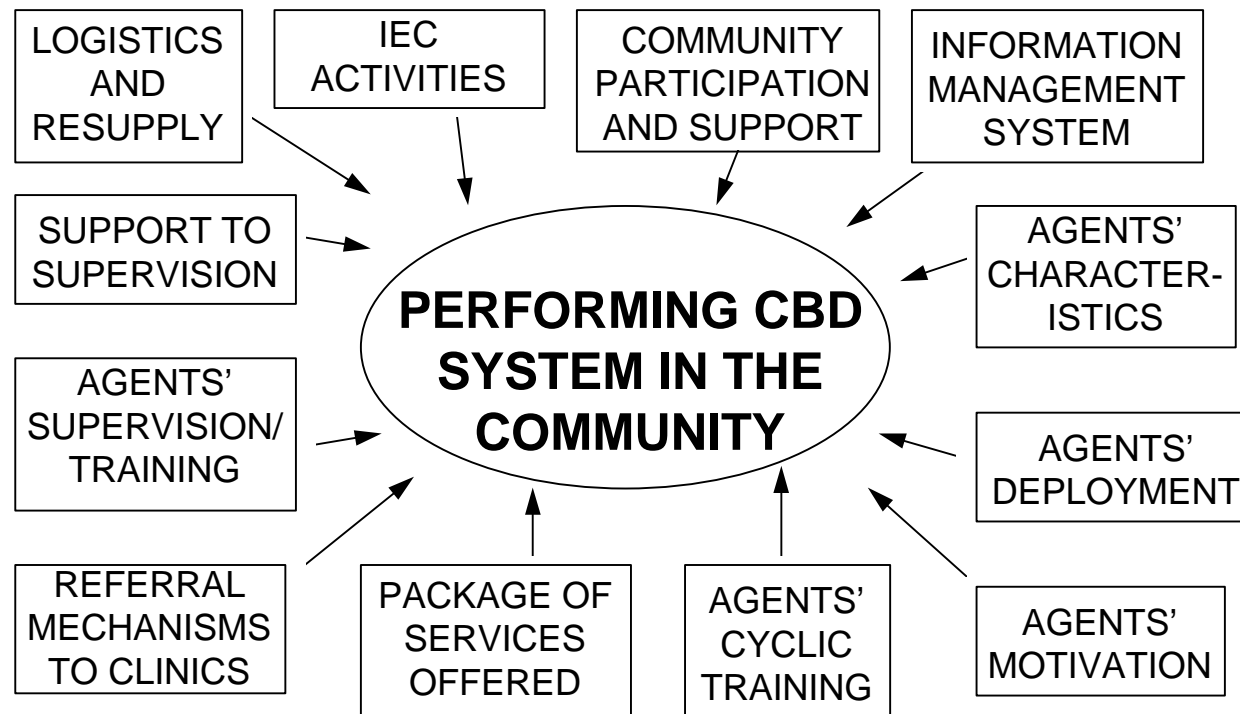
More than 80 indicators have been developed or adapted for use in monitoring the process, and/or evaluating the outputs, outcomes, and impact of PRIME training and capacity building interventions. In specific country project sites (e.g., India and Ghana) additional training indicators and benchmarks were used for specific project evaluations and to meet the specific data needs of the host country institutions and USAID Missions in those countries. The PRIME project preceded the incorporation of the results framework in USAID project designs. Some adjustments were necessary during the course of the project so that, in addition to monitoring the project deliverables and evaluating the original objectives of the project, additional data was also collected on indicators that more directly link to the new strategic objectives and intermediate results of USAID/Washington and/or the specific country USAID Missions where PRIME has been working for the past four years.

The PRIME evaluation activities operate on the macro level (policy), the intermediate level (programmatic: training events and methods, trainees, and workplace environment (PIA)); and the base level (services/client/community). Pre-post training surveys and follow-up assessments from one to six months after PRIME training were conducted for a number of PRIME projects globally to assess provider knowledge, skills, and the percentage performing to standards before and after training. These are the most basic evaluation activities of the PRIME project.

However, evaluation of PRIME's capacity building efforts for in-country training institutions is another key evaluation effort of PRIME, and a series of capacity building indicators, including a complex index of training capacity building (using 21 indicators) have been developed. A few impact evaluations have been undertaken such as an assessment of the impact of implementation of national training guidelines in reproductive health in Ghana (evaluation is not yet completed and FHI is taking the lead in this research). An evaluation of the impact of PRIME training on family planning program performance and service utilization in Tanzania has been completed in cooperation with first the EVALUATION and later the MEASURE projects of the Carolina Population Center, University of North Carolina.

## APPENDIX F

# THE PRIME COMPLETE SYSTEMS APPROACH TO CBD<sup>1</sup>



## APPENDIX G

### List of PRIME Documents Provided to Evaluation Team

#### *INTRAH Tools and Guidelines*

- Sustainability, Capacity Building, and Institutionalization in PRIME
- STI Prevention and Treatment in PRIME
- PRIME Evaluation and Research Plan, Volume II: PRIME Evaluation and Research Purposes, Policies and Standards
- PRIME Evaluation and Research Plan, Volume II: PRIME Evaluation and Research Purposes, Policies and Standards
- Technical Supervisory Protocols for Community Based Distribution (CBD) of Contraceptive Services, PPAG/INTRAH/USAID, June 1997
- Curriculum on Family Planning/Reproductive Health Supervision and Monitoring Skills for MCH Coordinators, Volume I: Content Outline; Volume II: Trainer's Materials; Volume III: Trainee's Materials

#### *External Evaluation Scope of Work Response*

#### *Contract Deliverables*

- PRIME. September 1997. PRIME at Midpoint: Progress toward Reaching Contract Objectives and Expectations.
- PRIME. 1998. PRIME Achievements and Impact: 1996-1997.
- PRIME at Year 4
- PRIME Objectives/Deliverables, end of year 1998

#### *USAID Management Reviews/3<sup>rd</sup> year organizational restructuring*

- Management Review, February 1996
- Management Review, February 1997
- Management Review, March 1997

#### *Annual Workplans*

- 1996 Annual Workplan
- 1997 Annual Workplan
- 1998 Annual Workplan
- 1999 Annual Workplan (draft)

#### *Country Strategic Training Plans*

#### *Dissemination Strategy Plans*

- PRIME Publications and Technical Materials
- PRIME Global/Regional Publications and Technical Materials
- DRAFT PRIME Publications Catalogue

#### *Monitoring and Evaluation Tools*



- PRIME Evaluation and Research Plan
  - Volume I: Focus, Approaches, Methods and Guidelines
  - Volume III: Formats, Protocols and Instruments

*Documentation for Key Countries: Ghana , Tanzania, India*

## **Ghana**

- Trip Report #P-106, December 8-18, 1997; Purpose: To prepare and conduct an impact monitoring of CBD private maternity home assistants training on RH/FP services accessibility and use, in collaboration with the Ghana Registered Midwives Association (GRMA)\*
- Trip Report #P-136, January 26-28, 1998; Purpose: To participate in the USAID 1998 cooperating agency meeting
- Assessment of GRMA's Public Sector Reproductive Health Service Providers Technical Report, April - May 1997
- PRIME Assessment of GRMA's Private Sector Reproductive Health Service Providers, Appendices, GRMA/INTRAH/PRIME, April/May 1992
- PRIME Initiative Working Document, Decentralizing and Integrating Life-Saving Skills and Postabortion Care Through the Safe Motherhood Program in Ghana, October 1998
- An Innovative Learning Approach to Improving Client-Provider Interaction and Family Planning/Reproductive Health Service Quality and Access in Ghana
- Quality of Care Improvements in Clinic Based and Non-clinic Based Reproductive Health Services (Phase II)
- Republic of Ghana National Reproductive Health Service Policy and Standards, November 1997

## **Tanzania**

- Proposal for the Evaluation of the 1994-1999 Tanzania Family Planning National Training Program, January - March 1999
- DRAFT PRIME Technical Report, A Training Strategy at Work in Tanzania: What Tanzania Service Availability Survey 1996 Tells us About the Contribution of Training to Family Planning Services, January 1998
- UMATI Training Project for Quality and Expansion of Family Planning and Selected RH Service Delivery, proposal for PRIME assistance, 1995 - 1999
- Tanzania INTRAH/PRIME Training and Technical Assistance Project, proposal for PRIME assistance, July 1995 - 1998
- Tape Talk Technology for Low Literate Health Care Service Providers in Remote and Underserved Rural Areas in Tanzania, 1997 (APHA 1997 handout)
- A Study to Determine Factors Affecting IUCD Use in Tanzania, proposal for PRIME assistance, September - December 1998
- United Republic of Tanzania, Contraceptive Technology/Reproductive Health and Training Skills Update Curriculum, Volume 1: Trainer's Materials, March 1996

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## **India**

- Trip Report #P-3104, January 30 - February 17, 1998; Purpose: To identify effective strategies to integrate postabortion care activities into existing IFPS reproductive health initiatives in Uttar Pradesh by (1) coordinating a PAC service delivery site assessment; and (2) facilitating a two day meeting on PAC
- Training of Indigenous Systems of Medicine and Homeopathic Practitioners in Non-clinical Methods of Family Planning
- Community Partnership for Safe Motherhood
- Performance-Based Training of Traditional Birth Attendants in Maternal Health and Non-clinical Family Planning
- AASRAA Series. Undated. Training of Registered Ayurvedic, Unani, and Homeopathic Practitioners in Sitapur and Jhansi Districts, Uttar Pradesh. Prepared for SIFPSA with Technical Assistance of The Policy Project.
- MotherCare/JSI, PRIME, and Shramik Bharti. September 1998. Referral Facility Assessment: Maitha Block, Kanpur Dehat Uttar Pradesh. Community Partnership for Safe Motherhood.
- POLICY Project. October 1997. Impact of PRIME training support activities on FP Services provided by ISM Practitioners in UP/India.
- PRIME. February 1998. Site Assessments: Post Abortion Care in Reproductive Health Facilities in Uttar Pradesh. Technical Report. Attachment 1.
- PRIME. December 1997. Training Needs Assessment Report: Training Needs for Clinical Family Planning Training of the Indian Medical Association in Uttar Pradesh
- PRIME (Sibley, Lynn and Bimal Buch). September 1995. Follow-up Assessment of the Indian Medical Association (IMA) Family Planning Clinical Training Course in Gujarat. Final Report.
- PRIME (Sadana, Rajeev and Alfredo Fort). August 1998. Assessment of Sub-centers in Jhansi District in Preparation for Clinic-based Family Planning (CBFP) Training and Upgrading. Technical Report.

## *Other Country-Specific Documentation*

- PRIME (Sharon Blake and Rajeev Sadana). January 1999. Results of Institutional Strengthening Needs Assessment and Proposed Plan for NGOs training organizations in Bangladesh.
- PSI/INTRAH/PRIME. December 1998. Rapport Technique: Suivi du Personnel des Pharmacies Forme dans le cadre du Programme de Marketing Social au Benin. Partie

1. Draft.

- PRIME/INTRAH (Perle Combary) and Ministry of Health. September 1995. Diagnostic Assessment of the Performance Potential of Front Line Health Workers for CBD Supervision in Bazega Province, Burkina Faso.
- IMSS-PRIME Proyecto (Dianne Catotti). January 1999. Strengthening the Integrated Reproductive Health Training System for Primary Level Personnel of the Mexican Social Security Institute (IMSS). Report on the IMSS-PRIME Project. Draft still under review.
- PRIME (Adelina Barrera and Jane Stein). 1998. Structural and Individual Factors Related to the Effectiveness of CBD Promoters in Nicaragua: FINAL REPORT.
- PRIME (Yvonne Sidhom, Zein Khairullah, Ashoke Shrestha, and Robert Timmons). 1997. Final Project Review Report of PRIME Project Support to the Oman Birth Spacing Program from June 1995 to June 1997.
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- PRIME (Yvonne Sidhom and Vinay Kumar). 1997. PRIME Support to the National Program to Expand Community Midwifery Training in Yemen. Final Project Report.

*Other Documents*

PPAG/INTRAH/PRIME. March 1998. Study of the Impact of Technical Supervision Training on CBD Supervisor's Performance. Final Report.